ADOLESCENCE, EMOTIONAL AND BEHAVIORAL PROBLEMS, AND COUNSELING: WHERE'S THE STIGMA?

By

CAROLINE ELDER DANDA

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2002

ACKNOWLEDGMENTS

There are many people who contributed to the successful completion of this project. I would like to thank my committee members, with special thanks to my cochair Suzanne Bennett Johnson for her enthusiasm and insight and for being an excellent role model. Special recognition goes to my chair Garret Evans, whose encouragement, thoughtful guidance, and confidence in me throughout graduate school and this project have been instrumental in developing my identity as a researcher and clinician.

Data collection would not have been possible without the cooperation of Gloria Spivey as well as the staff, teachers, and students at Columbia High School. Additional recognition goes to the team of people who helped with data collection and/or data entry, including Amy Baughcum, Kim Kirkpacktrick Justice, Rebecca Kristal, Rachel Nitzberg, Abby Sia, Jessica Stilley, and Brenda Wiens.

I would also like to express my gratitude to my good friend and colleague, Beth Bryant. Together, we weathered many storms and celebrated many milestones. Thanks also go to my parents, who told me I could achieve anything that I wanted if I worked hard enough and supported my decision to enter the field of psychology. Last, but most certainly not least, I thank my husband and best friend, Matt, who unconditionally supported and encouraged me through the stress of the dissertation and graduate school and was willing to make the sacrifices that are an inherent part of being a spouse of someone going through these processes.

TABLE OF CONTENTS

page

LIST OF TABLES

LIST OF FIGURES

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

ADOLESCENCE, EMOTIONAL AND BEHAVIORAL PROBLEMS, AND COUNSELING: WHERE'S THE STIGMA?

By

Caroline Elder Danda

August 2002

Chair: Garret D. Evans
Cochair: Suzanne Bennett Johnson
Major Department: Clinical and Health Psychology

Using a vignette methodology, this study examined adolescent attitudes toward common emotional and behavioral problems and school-based counseling within a rural community. Participants included 442 high school students from rural Florida. Peers described as exhibiting behaviors associated with depression, family conflict, and conduct disorder were consistently rated less favorably than peers without any problems, with particularly strong effects for conduct disorder. Stigma (i.e., negative attitudes) attached to emotional and behavioral problems appeared stronger than the stigma attached to counseling. Although peers without apparent psychological problems were rated less favorably if they attended counseling, they were still rated significantly more favorably than peers with problems, regardless of their counseling status. Gender, rurality, perceived similarity, prior counseling experience, and ethnicity moderated some of the effects related to emotional and behavioral problems and counseling status. For

example, adolescents characterizing themselves as living in the country rated peers who attended counseling less favorably than those living in town, which suggests that adolescents living in the country may be less tolerant or understanding of peers who attend counseling. Males and females also had significantly stronger and opposite reactions to their same-sex peers with depression. Females viewed their same-sex peers with depression in counseling most positively, and males viewed their same-sex peers with depression less positively compared to those with family conflict but not conduct disorder.

This study indicated that the manifestations of emotional and behavioral problems seem to impact attitudes more than counseling, per se. Consequently, the message that counseling can help ameliorate emotional and behavioral problems that might already be negatively impacting social relationships, and seems to have little additional negative effects with respect to adolescent attitudes, can help allay adolescent and parental concerns about their children attending counseling with a psychologist. Education about the nature and prevalence of common emotional and behavioral problems as well as the effectiveness of counseling in addressing these problems should be an integral part of any school-based mental health program in order to foster more open discussion of mental health issues, and perhaps lead to less stigmatization and more support among the peer group.

INTRODUCTION

Prevalence of Mental Disorder in Children

Estimates of adolescent emotional and behavioral difficulties range from 11-22% (Cohen & Hesselbart, 1993; Kashani et al., 1987; Offord et al., 1987; Whitaker et al., 1990). Emotional disturbances begin to occur at increased rates in adolescence (Achenbach, Howell, Quay, & Conners, 1991; Dubow, Lovko, & Kausch, 1990; Offer & Schonert Reichl, 1992), with depression, eating disorders, family conflict, conduct disorder, and substance abuse among the most frequently reported problems (Anglin, Naylor, & Kaplan, 1996; Dubow et al., 1990; Kashani et al., 1987; Whitaker et al., 1990). Estimates from the Office of Technology Assessment (1991) further suggest that 18-22% of adolescents have emotional disorders that warrant intervention.

With respect to gender, overall prevalence rates of emotional and behavioral problems are relatively equal. Although males tend to have higher prevalence rates of disorder in childhood, females evidence increased symptomatology and distress (e.g., emotional disorders) during adolescence, leading to comparable prevalence rates between the sexes during the adolescent years (Dubow et al., 1990; Offord et al., 1987). However, male and female prevalence rates differ by type of disorder. Adolescent males tend to exhibit more externalizing difficulties (e.g., behavior disorders and substance abuse) whereas adolescent females exhibit more internalizing difficulties (e.g., eating disorders, dysthymia, and depression) (Ostrov, Offer, & Howard, 1989; Whitaker et al., 1990).

Compared to urban areas, prevalence rates of child and adolescent mental health problems in rural areas do not differ greatly (Farmer, Stangl, Burns, Costello, & Angold, 1999), despite living conditions being characterized as idyllic in rural settings. In addition, declines in traditional economic bases (e.g., farming, resource extraction, and low-technology manufacturing) and related factors, such as poverty, substandard housing, and family disruption, have placed some rural residents at higher risk for emotional disorders (Kelleher, Taylor, & Ricker, 1992; Kenkel, 1986). Indeed, the farm crisis in the 1980s and mid-1990s and the associated rural economic decline have been associated with increases in withdrawal, depression, family violence, and substance use among rural adults and adolescents (Garfinkel, Hoberman, Pasons, & Walker, 1988, as cited in Kelleher et al., 1992; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994).

Service Utilization

Despite high prevalence rates of emotional and behavioral problems among adolescents, the majority of these youth receive either inadequate or no mental health services at all (Leaf et al., 1996; Offord et al., 1987; Whitaker et al., 1990). Only about one-third to one-half of youths who need services actually receive them (Surgeon General, 2000; Office of Technology Assessment, 1991). For example, in a community study of self-reported mental health needs and help-seeking, only half of those who indicated a need for help actually sought it (Saunders, Resnick, Hoberman, & Blum, 1994). Similarly, Rickwood and Braithwaite (1994) reported that approximately one-quarter of adolescents identified themselves as distressed on a self-report measure, but only 17% of these individuals sought professional help. Although self-report methodologies and degree of impairment may inflate rates of emotional and behavioral

problems, studies using structured interviews and diagnostic criteria for mental disorders have found similarly low levels of utilization. Whitaker and colleagues (1990) found that less than half of adolescents who screened positive for a lifetime diagnosis of a disorder and were currently experiencing impairments in functioning had received any professional services. Likewise, Offord and colleagues (1987) found that only 16 % of children with a diagnosable disorder had received services within the last 6 months.

Studies of service utilization, however, often employ broadly inclusive definitions of mental health professionals and mental health contacts. For example, Rickwood and Braithwaite (1994) included family doctor, general mental health services, and educational help services in the category of professional help. Others have not specified the source of help (Saunders et al., 1994) or the nature of the help; in such cases, a reported mental health contact may not be a valid indicator of actual treatment received (Leaf et al., 1996). The lack of definition related to mental health service use likely leads to overestimation of service use. For example, Zahner, Pawelkiewicz, DeFrancesco, and Adnopoz, (1992) found that although 51% of children who were identified as having emotional and behavioral problems by both teachers and parents reported using services for such problems, only 11% used services within the mental health sector. Offer, Howard, Schonert, and Ostrov, (1991) found that among 500 adolescents, 22% reported experiencing emotional and behavioral difficulties, but only one-third of these adolescents sought help from a mental health provider, and only 20% actually entered treatment (i.e., participated in more than 3 sessions).

Finally, some evidence suggests that youths with severe and/or multiple disorders are more likely to receive services, but as many as two-thirds still remain untreated (Leaf

et al., 1996). Moreover, if most mental health treatment has been directed toward those with more chronic, severe mental disorders, an even greater gap in service delivery exists for children and adolescents with lower levels of symptomatology who still demonstrate significant impairment (e.g., poor academic performance, problematic interpersonal relationships, etc.). Essentially, these are the youths who are at risk for developing more serious, chronic emotional and behavioral disorders that could be prevented if they received early treatment. Indeed, the 1991 "Adolescent Health. Volume I. Summary and Policy Options" report (Office of Technology Assessment, 1991) suggested that adolescents who have subclinical mental health problems and who are unaware of available services are at the greatest risk of falling through the cracks. Given that more than two-thirds of adolescents do not receive sufficient or adequate treatment, greater efforts need to be directed toward providing mental health services to these youths and encouraging the use of these services among adolescents.

School-Based and School-Linked Mental Health Services

Schools often serve as the first point of contact for mental health problems and subsequent referrals. Several researchers have even suggested that schools have become the "de facto" mental health system, despite the fact that they may have little overlap with specialty mental health services (Burns et al., 1995; Leaf et al., 1996; Zahner et al., 1992). Integrated systems of care within the school setting, such as school-based and school-linked health services, initially targeted physical health concerns; however, mental health services were gradually incorporated, in part due to increased attention to adolescent problem areas, such as teen pregnancy, risk-taking behaviors, substance abuse, violence, depression, and suicide (Flaherty, Weist, & Warner, 1996). Partnerships and

interagency collaborations between schools and community/academic mental health providers have allowed for the inclusion of mental health services in school-based and school-linked clinics.

Currently over 900 school-based and school-linked health centers operate nationwide, the majority of whom (86%) provide some type of counseling services (Fothergill & Ballard, 1998). School-based and school-linked services may be particularly well-suited for rural areas, which typically have fewer mental health resources and more fragmented service delivery systems than urban and suburban communities (Cohen & Hesselbart, 1993; Kelleher et al., 1992). Schools offer centralized locations that are ideal for initiating referrals, coordinating a system of care, providing continuity of care, and promoting better treatment planning and generalization. Therapists can speak directly with guidance counselors or teachers to gain more information about the nature of a problem a child is experiencing as well as collaborate with them to facilitate generalization of treatment gains across settings. Students may also be more amenable to counseling if suggested by guidance counselors with whom they have frequent contact and a trusted relationship. Issues impeding follow-through with mental health service referrals, such as transportation and poor communication with referral sources, are far less problematic within a school-based system of care (Santelli, Morreale, Wigton, & Grason, 1996). Cost also becomes less of a barrier as agencies often partner with schools to provide mental health services at reduced fees or free of charge (G. D. Evans & Rey, 2001; Fothergill & Ballard, 1998). Services that occur within the school setting and/or during school hours also reduce the burden on the family to bring the child to weekly appointments (Santelli et al., 1996). Moreover, mental health services in the

context of the schools provide a sense of familiarity and may eventually be considered part of the routine services offered, thereby reducing the stigma that may be associated with attending a mental health treatment center.

Data regarding service utilization suggest that school-based and school-linked services represent a viable treatment option for adolescent mental health problems. Research examining school-based health services (both physical and mental health) reported that approximately 20-25% of all visits were related to mental health (Anglin et al., 1996; Balassone, Bell, & Peterfreund, 1991). Some data even suggest increased utilization of school-based mental health services relative to other forms of service delivery, such as hospitals or outpatient clinics (Anglin et al., 1996; S. W. Evans, 1999). Moreover, many adolescents perceived school-based mental health services as helpful, approachable, and even confidential (Balassone et al., 1991; S. W. Evans, 1999), and a recent outcome study demonstrated that youths who received school-based services demonstrated decreased levels of depression and improvements in their self-concept (Weist, Paskewitz, Warner, & Flaherty, 1996).

Barriers to Help-Seeking

Although school-based mental health services appear to be effective, a large number of adolescents do not receive the treatment they need, often due to a reluctance to seek help (i.e., counseling). Adolescents may be reluctant to seek services because of the personal nature of problems as well as concerns about what goes on in therapy, confidentiality, privacy, and feelings of embarrassment (Adelman & Taylor, 1993; Balassone et al., 1991; Taylor, Adelman, & Kaser Boyd, 1985). The school setting can certainly exacerbate these concerns about confidentiality and privacy. An adolescent may

be called out of class, or at least be absent from class, to attend counseling with a psychologist. Peers may also have increased opportunities to see an individual enter the therapist's office. Indeed, recent evidence suggests that confidentiality and privacy are of utmost concern in the school setting. Riggs and Cheng (1988) found that adolescents experiencing emotional problems would only use a school-based clinic if confidentiality was guaranteed. Similarly, families unfamiliar with school-based services rated confidentiality as a significant concern as compared to traditional clinic-based services (S.W. Evans, 1996, as cited in S.W. Evans, 1999).

Confidentiality concerns are only heightened by the potential stigma associated with receiving mental health counseling. Adolescents may be worried peer reactions to the discovery that the adolescent is seeing a psychologist for counseling. Although Day and Reznikoff (1980) reported that young boys (aged 7-12 years) referred for therapy were concerned about neighbors or teachers finding out, scant attention has been given to adolescents' attitudes toward mental health problems and counseling, and even less attention to whether children and adolescents negatively evaluate or behave negatively toward (i.e., stigmatize) individuals who have emotional and behavioral problems or attend counseling.

Understanding adolescent attitudes and actions toward common emotional and behavioral problems and counseling may be even more important in rural areas where fears of being labeled as mentally ill or stigmatized have often been cited as a significant barrier to seeking psychological treatment (Berry & Davis, 1978; Kenkel, 1986; Surgeon General, 2000). Traditional rural values, such as self-reliance, autonomy, conservatism, and distrust of outsiders are often incompatible with help-seeking (Hoyt, Conger, Valde,

& Weihs, 1997; Kelleher et al., 1992; Wagenfeld et al., 1994). Rural residents often rely on informal sources for help (e.g., family, friends, religious leaders), ignore, deny, and minimize problems (Kelleher et al., 1992; Kenkel, 1986), and tend to be less familiar with routine therapy services. Prior to the establishment of Community Mental Health Centers (CHMC) in 1963, the mental health needs of rural residents were virtually ignored (Hargrove & Breazeale, 1993). The resources provided by CMHC, however, were largely dedicated to treatment of the chronically and severely mentally ill. Given that many rural residents' experience and knowledge of mental health treatment likely stems from their perceptions of CHMCs, it is not surprising that they might equate all mental health services with treatment for chronic and severe mental illnesses. Stigma related to such mental health problems may infect stigma for all mental health services. In this respect, many rural residents lack knowledge about existing mental health services, common emotional and behavioral problems, and the effectiveness of psychological counseling in addressing these problems (Berry & Davis, 1978).

The movement toward integrated school-based mental health services ameliorates issues of accessibility and availability, particularly in rural areas, and raises the question about barriers, such as stigma, that may impede adolescent utilization such services.

Attitudes toward Mental Illness

Adult Perceptions

Negative evaluations toward the severely and chronically mentally ill have been widely documented among adults. Nunnally's (1961) classic studies found that the public generally held negative views of the mentally ill, frequently ascribing to them characteristics such as worthless, dirty, dangerous, cold, unpredictable, and insincere.

Early studies suggested that those with mental illness were to be feared, avoided, perhaps controlled but also treated with kindness (Hayward & Bright, 1997). Even now, the public often seems to have a restricted view of mental illness, limited to severe mental illness, such as schizophrenia and other conditions requiring hospitalizations. Indeed, Hayward and Bright (1997) argued that people are reluctant to label all but the most extreme forms of behavior as mental illness, suggesting that the general population has a predisposition to interpreting mental illness as a severe, chronic condition. Consequently, it is not surprising that common public misconceptions include views of the mentally ill as "homicidal maniacs who need to be feared," people with "childlike perceptions of the world that should be marveled," and "rebellious, free spirits" (Corrigan & Penn, 1999, p. 766). Although recent conceptions of mental illness have expanded to include anxiety and depression, many people still associate the term mental illness with a psychotic condition that includes violent and unpredictable behaviors that should be feared (Surgeon General, 2000).

Such negative evaluations, or stereotypes, may prevent people from seeking treatment, particularly for less chronic and severe conditions, for fear of being labeled and stigmatized as mentally ill (Hayward & Bright, 1997). Although stigma is often cited as a barrier to seeking treatment, little research has examined stigma and attitudes regarding individuals who seek outpatient treatment, particularly for less severe behavioral and emotional problems. Although evidence suggests that current psychotherapy clients may not perceive stigma associated with seeking help as a salient problem (Halgin & Weaver, 1986), Stefl and Prosperi (1985) found that those in need of services who did not utilize them anticipated levels of stigma (i.e., feared being looked

down upon or their neighbors and friends finding out) almost two times higher than individuals who needed help and sought it. Thus, it appears that concerns about stigma represent a significant barrier to help-seeking among individuals in need of mental health services.

Child and Adolescent Perceptions

Studies of children's views of mental illness also suggest generally unfavorable views. Compared to medically ill, handicapped, or learning-disabled youths, children rate emotionally disturbed peers less favorably (Parish, Ohlsen, & Parish, 1978), view them as less attractive (Novak, 1974; Roberts, Johnson, & Beidleman, 1984) and perceive such peers as less similar to themselves (Novak, 1974). Even when children hold generally positive perceptions of peers with mental disorders, they still attribute more negative characteristics to them compared to children without a mental disorder (Friedrich, Morgan, & Devine, 1996). Likewise Lopez (1991) found that while adolescents may not necessarily see people with mental illnesses as dangerous, they still view them as relatively unpredictable.

More detailed examinations of attitudes toward psychological problems suggest attitudes may also vary according to type of problem. Children as young as elementary school can differentiate between normal and deviant peers and often make distinctions among disorders (Chassin & Coughlin, 1983; Coie & Pennington, 1976; Marsden, Kalter, Plunkett, & Barr-Grossman, 1977). In particular, aggressive behavior is consistently rated as more deviant and viewed more negatively (Coie & Pennington, 1976; Hoffman, Marsden, & Kalter, 1977; Marsden et al., 1977). The greater negative perceptions of aggressive behavior might be partially explained by a belief that aggressive behavior

represents a lack of self-control and adherence to social norms (Roberts et al., 1984) and is consistent with research that has found aggression to be one of the strongest predictors of rejection by the peer group (Coie, Dodge, & Kupersmidt, 1990). Further, research has demonstrated that behaviors such as fighting, group disruption, and irritable tempers are consistently related to negative peer evaluations (Inderbitzen-Pisaruk & Foster, 1990). Shyness and withdrawn behavior, which could be related to depression, have also been associated with children being neglected, but not rejected (Inderbitzen-Pisaruk & Foster, 1990).

With increasing age, conceptions of mental illness become more complex and abstract. Older children make better distinctions between deviant behavior associated with mental disorder versus behavior associated with social norm violations, demonstrate greater insight about the causes of deviant behavior, and show greater differentiation between types of mental disorders (Chassin & Coughlin, 1983; Coie & Pennington, 1976; Offer & Schonert Reichl, 1992; Sigelman & Mansfield, 1992). For example, Sigelman and Mansfield (1992) found that adolescents were less willing to see a psychologist for less serious problems; reluctance to seek treatment was most evident when symptoms were not psychological in nature or reflected nonconformity or normality. Younger children consistently rated mental disorders more negatively in general, while adolescents were less consistent in their ratings, suggesting that adolescents were better able to differentiate among the disorders (Sigelman & Mansfield, 1992). Once children reach adolescence, however, there may be fewer changes in their conceptions of mental disorders (Lopez, 1991).

With respect to gender, adolescent females tend to have more favorable views toward individuals with mental illnesses than males. For example, Lopez (1991) reported that adolescent females viewed individuals with mental illness as more similar to themselves, saw them as less of a threat to society, endorsed more nurturing attitudes toward them, and were more willing to interact with them. Likewise, Norman and Malla (1983) found that females demonstrated greater social acceptance of peers with psychological problems as well as a stronger belief in psychosocial etiology and a more positive prognosis for these problems.

In sum, both adults and children appear to hold somewhat negative views of mental disorders. However, much of the research has focused on attitudes toward severe, chronic mental disorders, such as schizophrenia, or toward individuals who have been hospitalized for mental illness, rather than more common emotional and behavioral problems. Research on children's conceptions of psychological disorders has been conducted primarily with younger populations; much less attention has been directed toward adolescent perceptions. Research in this area also tends to be qualitative and descriptive, often assessing general knowledge of psychology rather than specific information about common emotional and behavioral problems, or uses dated, adult measures or adult vignettes. Even less is known about general attitudes toward therapy or mental health counseling, per se.

Attitudes Toward Counseling/Therapy

Adult Perceptions

The literature on adult perceptions toward individuals who seek psychological treatment suggests neither entirely positive nor negative attitudes. Crisp, Gelder, Rix,

Meltzer, and Olwen (2000) found that the public held relatively accurate opinions about the ability to treat several mental health problems and held somewhat optimistic views about their prognosis. Nunnally (1961) also found that the general public holds moderately favorable attitudes toward mental health professionals, which suggests that the treatment they offer may also be viewed positively. Evidence also exists suggesting that individuals with emotional and behavioral problems who seek treatment may be viewed as more competent (Dovidio, Fishbane, & Sibicky, 1985). Likewise, Schwarzer and Weiner (1991) found that individuals with medical and psychological problems received less blame or anger and more pity if they were perceived as actively coping with their illness. Although examples of active coping were only provided for physical illness (e.g., adherence to medical regimen), one might surmise that seeking mental health counseling would constitute one element of active coping for a psychological disorder, such as anorexia or depression.

However, a survey by the American Psychological Association (1996) suggested that adults lack knowledge about how to access mental health services and what problems are appropriately treated by a psychologist, suggesting that people may be largely uninformed and naïve about current psychological services and practices. In addition, several studies found that compared to a control group, individuals labeled as seeking mental health treatment (e.g., psychiatrist, psychiatric hospital, counseling center) were viewed less favorably than control groups (Parish & Kappes, 1979; Phillips, 1963; Sibicky & Dovidio, 1986). Dovidio and colleagues (1985) also found that while people attributed some positive characteristics (e.g., competence) to individuals with problems who sought help, they were still rated unfavorably on other dimensions (e.g., sociability)

(Dovidio et al., 1985). Seeking mental health treatment may automatically generate negative stereotypes associated with having psychological problems or "mental illness." For example, Piner and Kahle (1984) found that confederates who were "ex-mental patients" were viewed as more unusual than controls, even when the confederates actual behavior did not differ from the controls. Similarly, Phillips (1963) argued that contact with psychiatrist or treatment at a mental hospital generates labels linked to the mentally ill or insane, given the greater social rejection that occurred for these two help sources as compared to a physician or clergyman. However, differences in social rejection were much more prominent for mental disorders than for mental health treatment, suggesting that the behaviors associated with a psychological problem may be more related to social distancing than help-seeking itself (Phillips, 1963, 1964).

Children's Perceptions

Studies examining children's conceptions of psychological treatment have also generated mixed findings. In a study by Dollinger and Thelen (1978), few children (10%) had positive attitudes toward seeing a psychologist, most children's attitudes were neutral (60%), and derogatory expressions about psychologists or people who see psychologists were relatively rare. Notably, derogatory expressions were slightly higher among boys. Sigleman and Mansfield (1992), found that a considerable number (68%) of youths reported negative feelings (e.g., anxiety) toward therapy. Cross-sectional samples involving elementary, middle, and high school youths suggest few differences as a function of grade or age (Dollinger & Thelen, 1978; Sigelman & Mansfield, 1992).

Research involving adolescents specifically, however, suggests that some may view psychiatric hospitalization and outpatient therapy as beneficial and understand the

risks and benefits associated with therapy, particularly if they had experience with therapy (Kaser Boyd, Adelman, & Taylor, 1985; Pugh, Ackerman, McColgan, & de Mesquita, 1994). While adolescents felt that psychiatric hospitalization was associated with stigma, particularly among their peers, they considered peer stigma for outpatient therapy a relatively rare occurrence (Pugh et al., 1994). With respect to gender, females have been found to endorse some form of treatment for psychological problems more often than males (Chimonides & Frank, 1998; Pugh et al., 1994).

Adolescent Help-Seeking

Research from the adolescent help-seeking literature suggests that they are often unaware of mental health resources (Dubow et al., 1990) and prefer to seek help from informal sources (e.g., friends and family) as opposed to more formal mental health services (Offer & Schonert Reichl, 1992; Rickwood & Braithwaite, 1994). Further, adolescents cite confidentiality and privacy as concerns about seeking treatment (e.g., (Balassone et al., 1991; Dubow et al., 1990), suggesting they have concerns about being stigmatized should they seek psychological services.

Factors associated with adolescent help-seeking include gender, previous exposure to therapy, ethnicity, parent education, parent marital status, and symptom level. For example, females and those with interpersonal problems tend to hold more positive attitudes toward seeking informal help (Boldero & Fallon, 1995; Garland & Zigler, 1994; Schonert-Reichl, Offer, & Howard, 1995) as well as formal professional help (Rickwood & Braithwaite, 1994). Females also seek help from friends more frequently, whereas males tend to seek help from parents (Dubow et al., 1990).

Research suggests that African-Americans are more likely to seek out family and friends for help rather than a mental health provider (McMiller & Weisz, 1996). Similarly, minorities are less likely to contact a mental health professional and more likely to wait until problems are more severe before seeking professional help (McMiller & Weisz, 1996; Padgett, Patrick, Burns, & Schlesinger, 1994; Schonert-Reichl et al., 1995).

Prior participation in therapy has been associated with more favorable attitudes and increased willingness to seek help in general (Rickwood & Braithwaite, 1994). Adolescents who have had previous psychological treatment also see therapy as more beneficial and minimize the risks associated with it (Kaser Boyd et al., 1985; Pugh et al., 1994).

Lower parental education, single parent status, lower self-image, lower grades, and lower SES have also all been associated with less frequent help-seeking (Saunders et al., 1994). Notably, many of these same variables have been associated with increased levels of psychosocial problems among youth. These adolescents may be in double-jeopardy—at-risk for having psychosocial problems but less likely to actually seek services. School-based or school-linked services may be a more effective means of reaching these youths, provided counseling with a psychologist, or other mental health professional, is seen as a viable option.

The Role of the Peer Group

The literature further suggests that peers may play an important role in adolescent help-seeking. Adolescents who experience psychological problems tend to seek help from peers, rather than parents or professionals; however, those who seek informal help

are also more likely to seek formal help (Offer et al., 1991; Saunders et al., 1994). Thus, the peer group, and particularly their prevailing attitudes toward mental health counseling and psychological problems, could strongly encourage or discourage professional help-seeking in adolescents. For example, adolescents with negative attitudes toward therapy could think less of adolescents who participate in counseling, make fun of them, or participate in fewer activities with them, thereby discouraging peers from entering counseling. On the other hand, if adolescents hold positive views about seeking professional help, they may encourage a peer who is having problems to seek counseling, particularly if it is easily accessible and available at school. Adolescents could even view the person more positively for getting the necessary help and "actively coping" with their problem.

Given that not all mental disorders are viewed equally by adolescents (Chassin & Coughlin, 1983; Coie & Pennington, 1976), adolescent perceptions of peers who seek counseling may differ, depending on the nature and severity of the problem. For example, it is doubtful that anyone would view therapy or hospitalization negatively for a person who is suicidal or having frank delusions. However, suicidality and psychosis only represent a small number of those who need psychological treatment. As mentioned earlier, a considerable number of adolescents with less "severe" emotional and behavioral disorders, such as depression or conduct disorder, do not receive the help they need. It is for these youth that peer group attitudes toward mental disorders and therapy are particularly important, but very little is known about whether stigma within the peer group exists. Examining the prevailing attitudes within the peer group can provide an important basis for intervention programming, leading to more favorable attitudes among

adolescents, in general, more open discussion of counseling, emotional and behavioral problems, and, perhaps, less stigmatization and more support among the peer group.

CONCEPTUAL BASES FOR THE CURRENT STUDY

Stigma

Stigma, in the context of social psychology, represents negative stereotypes toward a person or group of persons that can lead to prejudice or discrimination (Corrigan & Penn, 1999). Often, the negative effect occurs as a function of the label itself, rather than behavior. Indeed, a review of studies found that the label of "mental illness" or "mental patient" (often with no accompanying behavioral description) results in a negative evaluation (Hayward & Bright, 1997). But the inclusion of contextual variables, such as actual behaviors or details of a person's life, appears to lessen negative reactions. In this manner, attitudes toward the "label" of mental illness may not accurately reflect attitudes toward individuals. Specifically, people's reactions to a person labeled with a "mental illness or mental disorder" likely differ from their reactions to a person who has an emotional and behavioral disorder but who has not been "labeled" as mentally ill. In typical social interactions, a person observes or encounters the behavioral manifestations of an emotional and behavioral disorder prior to having knowledge of a specific label. Thus, most people are likely unaware of the name of the emotional and behavioral problem a person is experiencing without someone explicitly stating it. In contrast, the behaviors of an individual are more easily and readily observed and immediately impact the interpersonal interaction.

The literature also suggests that, in the absence of a label, the public refrains from labeling all but the most extreme behaviors as mental illness (Hayward & Bright, 1997). Rather, the public tends to associate the terminology "mental illness or mental disorder" with "severe mental illness," such as schizophrenia or other conditions that might require psychiatric hospitalization. Much of the research literature that examines general attitudes toward mental illness seems to reflect attitudes about severe mental illness rather than more common emotional and behavioral disorders, such as depression and anxiety. This study aims to go beyond measuring the stigma associated severe mental illness by using behavioral descriptions of disorders that are commonly found among adolescents.

Attitudes

Attitudes involve the favorable or unfavorable evaluations toward stimuli manifested in one's beliefs, feelings, or intended behavior (Myers, 1999). Essentially, attitudes represent ways to organize information so as to react more efficiently to people, events, and situations. In this manner, stigma might be considered a negative attitude and measured as such. At the same time, many in social psychology have argued that attitudes do not necessarily predict behavior in actual situations. Often this is the case when studies restrict the measurement of attitudes to the beliefs and feelings. The lack of relation between attitudes and behavior rings particularly true in cases where the beliefs measured are conceptually broad but the behaviors are specific (Ajzen & Fishbein, 1977). So, in order to increase the relationship between attitudes and actual behaviors, one should assess beliefs about specific situations or events as well as behavioral intentions, i.e., commitment to a future action (Siperstein, 1980). The inclusion of behavioral intentions also suggests a degree of acceptance, or willingness to interact socially with

the specified individual. Consequently, this study employs measures that assesses attitudes, in the form of cognitive and affective judgments, as well as acceptance, in form of behavioral intentions.

Vignette Methodology

Vignette research methodology offers the ability to specify and standardize information and thereby assess specific attitudes. Vignettes, which have been widely used in attitude research, are descriptions of specific situations relevant to the constructs under investigation (Alexander & Becker, 1978). They offer the advantage of simulating real-life decision-making situations systematically, so as to control for extraneous factors and randomize people to conditions (Alexander & Becker, 1978; Lanza & Carifio, 1992). Differences in the information in vignettes serve as different social cues; evaluative judgments and behavioral intentions in response to the vignettes are presumed to reflect differences associated with these cues. The systematic variation of such informational cues permits examination of effects related to one variable or combinations of variables (e.g., one can examine effects of gender of respondent alone or in combination with effects related to the type of emotional and behavioral problem described in the vignette). Written vignettes are also more cost-effective and more easily standardized as compared to videotaped presentations of actors playing different parts. Actors, themselves, might introduce additional elements, such as general appearance, that might bias responses related to social image. Finally, the use of vignettes may also reduce the impact of demand characteristics, impression management, and social desirability that can bias responses to direct questioning about attitudes (e.g., how do you feel about this person with depression?). When asked directly about specific attitudes, people may respond in a

manner that they perceive would please the interviewer or that is socially acceptable. By using a comparative contrastive technique, in which respondents only answer questions about one or two potential vignettes, respondents are often unaware of the specific information that has been manipulated (Burstin, Doughtie, & Raphaeli, 1980), potentially reducing some social desirability bias. Although vignette methodology offers many advantages, the stimuli presented are only simulated, and as such, generalization of findings is limited. Actual behaviors in real situations may vary. Despite this limitation, vignette methodology seems to provide a convenient, systematic way to assess general attitudes among a population. The inclusion of a measure of behavioral intentions should shed additional light on the potential link between attitudes and behaviors.

PURPOSE OF THE STUDY

The purpose of this study is to examine rural adolescents' attitudes and behavioral intentions toward peers who have emotional and behavioral disorders and who participate in school-based counseling with a psychologist.

Research Questions

Question 1: How do adolescents view peers with emotional or behavioral problems?

Question 2: How do adolescents view peers who participate in counseling with a psychologist?

Question 3: Do adolescents' views of peers change as a function of emotional and behavioral problems displayed and counseling status?

Question 4: Do adolescents' attitudes toward peers with emotional and behavioral problems and those who attend counseling vary as a function of gender?

Question 5: Do adolescents' attitudes toward peers with emotional and behavioral problems and those who attend counseling vary as a function of certain other respondent and demographic characteristics of the adolescent (e.g., perceived similarity to target adolescents, prior counseling experience, help-seeking attitudes, grade, ethnicity, and rurality)?

Hypotheses

The specific hypotheses outlined below are based on the existing literature and clinical experience. The hypotheses and subsequent analysis plan are categorized as primary or secondary. Primary hypotheses and analyses relate to the first four research questions and concern the effects of experimental manipulation and the gender of the respondent/target peer. The secondary hypotheses and analyses relate to the last research question and concern the potential moderating effects of respondent and demographic characteristics on adolescent ratings.

Primary Hypotheses: Experimental Manipulation

1. *Adolescents will view peers who display emotional or behavioral problems more negatively than peers with no reported problems.* Previous research suggests that younger children view emotionally-disturbed peers less favorably than medically-ill, handicapped, or learning disabled youth (Novak, 1974; Parish et al., 1978; Roberts et al., 1984). The same pattern likely exists within an adolescent sample.
2. *Adolescents will view peers with conduct disorder more negatively than peers with depression or peers reporting high family conflict.* Compared to those with other disorders, children with externalizing difficulties and behavior problems tend to be viewed less favorably (Coie & Pennington, 1976; Hoffman et al., 1977; Marsden et al., 1977). Furthermore, youth with conduct disorder are likely to exhibit behaviors that are more salient and problematic than those who experience depression or family conflict. Indeed, aggression, one component of conduct disorder, is one of the strongest predictors of rejection by the peer group (Coie et al., 1990). Adolescents may also attribute more personal responsibility and a lack of self-control to

adolescents exhibiting conduct problems. As such, conduct disorder likely elicits less sympathy than either depression or family conflict and would be viewed more negatively.

3. *Among peers who have no apparent emotional and behavioral problems, adolescents will view peers who participate in counseling less favorably than those who do not participate in counseling.* No known studies have examined children's or adolescents' attitudes toward peers who participate in counseling independent of the reason for counseling. Research with adults, however, suggests more negative views of individuals who seek mental health treatment as compared to individuals without apparent problems who do not attend therapy (Dovidio et al., 1985; Parish & Kappes, 1979; Piner & Kahle, 1984; Sibicky & Dovidio, 1986). Further, stigma may be associated with mental health treatment by proxy. In the absence of information about the type of problem, an adolescent may assume that a person attending counseling must be experiencing some type of mental health problem and subsequently attribute a negative stereotype, such as those that have been associated with "severe mental illness."
4. *Among peers who have emotional and behavioral problems, adolescents will view peers who attend counseling more favorably than peers who do not attend counseling.* Although behavioral manifestations and labels of emotional and behavioral disorders have negative connotations, individuals who seek counseling for these problems have been viewed as more competent (Dovidio et al., 1985). In addition, individuals seen as actively coping with their problem (i.e., doing something to alleviate the problem) may be viewed more favorably (Schwarzer & Weiner,

1991). As such, it is expected that adolescents will view peers who participate in counseling as actively coping with their problems and competent, and as a result, view peers with emotional and behavioral problems more favorably if they are participating in counseling.

5. *Adolescents' perceptions of peers who participate in counseling will also differ as a function of the type of emotional and behavioral problem displayed.* Given evidence that adolescents can discriminate among disorders (Chassin & Coughlin, 1983; Coie & Pennington, 1976; Offer & Schonert-Reichl, 1991), their perceptions of counseling may also vary depending on the disorder. For example, depression may be viewed as more internal to the person, biological, or as the result of situational factors. Compared to conduct disorder, depression may elicit more sympathy than conduct disorder and be viewed as a more valid reason for attending counseling. Alternatively, adolescents may perceive family conflict as a normative experience rather than a disorder, per se and thus, may view these peers less favorably for attending counseling for such a normative problem (Sigelman & Mansfield, 1992). Finally, although conduct disorder may be viewed as highly problematic and in need of treatment, peers with conduct disorder may be viewed so negatively that participation in counseling may not mitigate these views.
6. *Among peers who participate in counseling, adolescents will view peers <u>with</u> apparent emotional and behavioral problems more favorably than peers <u>without</u> apparent emotional and behavioral problems.* Knowing the reason for counseling (i.e., that the person is experiencing a specific emotional or behavioral problem) may mitigate negative attitudes toward peers who participate in counseling. In the absence

of explicit problems, adolescents might presume that an adolescent who attends counseling must have "serious problems" and attach the general label of "mental illness" or "mental disorder" it the peer, which would have negative connotations (Corrigan & Penn, 1999; Hayward & Bright, 1997). Consequently, it expected that the peers with emotional and behavioral problems who attend counseling will be viewed as actively coping with their problems and be viewed more favorably than peers who do not appear to have a valid reason (i.e., no apparent emotional and behavioral problems) for attending counseling.

7. *Males will view same-sex peers with depression more negatively, whereas females will view same-sex peers with conduct disorder more negatively.* Emotional problems, such as depression, are more common and seem to be more acceptable among females; whereas behavior problems, such as conduct disorder, are more common among males (Ostrov et al., 1989) and include behaviors that are less acceptable for females. Consequently, we expect that males will view peers with depression more negatively. Likewise, we expect females may view peers who exhibit overt conduct problems less favorably. Family conflict, however, is more pervasive across genders, and thus, no differences are expected between male and female ratings of peers with family conflict.
8. *Females will view same-sex peers who participate in counseling more positively compared to males.* Previous research has found that females hold more favorable attitudes toward help-seeking (Boldero & Fallon, 1995; Garland & Zigler, 1994), acknowledge their own need for help (Saunders et al., 1994), and endorse treatment

for a wider range of problems than males (Pugh et al., 1994). Consequently, it is likely that females will view peers who seek help more favorably than males.

9. *Males will view same-sex peers who are depressed and attend counseling most negatively; whereas, females will view same-sex peers who are depressed and attend counseling most positively.* Given that males are likely to view other males who are depressed more negatively and given their less favorable attitudes toward help-seeking (Boldero & Fallon, 1995; Garland & Zigler, 1994; Schonert-Reichl et al., 1995), it is expected that males would rate their same-sex peers who are depressed and attend counseling least favorably. For females, the opposite may be true. Females may view other females with depression more positively than other disorders, and given females' generally positive attitude toward help-seeking, it is expected that females with rate their same-sex peers with depression who attend counseling most positively.

Secondary Hypotheses: Respondent and Demographic Characteristics

Respondent characteristics

10. *Adolescents who have had prior experience with counseling will view peers who participate in counseling more positively than adolescents who have had no prior experience with counseling.* In adolescence, personal participation in mental health treatment has been associated with increased willingness to seek help, stronger endorsement of help-seeking for emotional and behavioral problems, increased perceptions of benefits and decreased perceptions of risks associated with mental health treatment (Kaser Boyd et al., 1985; Pugh et al., 1994; Rickwood &

Braithwaite, 1994). Consequently, adolescents with prior counseling experience are expected to provide more favorable ratings of peers who participate in counseling.

11. *Adolescents who have more positive attitudes toward help-seeking will view peers who participate in counseling more favorably than adolescents with more negative views of help-seeking.* If adolescents who hold positive views about help-seeking for themselves, it is expected that they will also view peers who attend counseling more favorably than adolescents who have lower help-seeking attitudes.
12. *Adolescents who perceive themselves to be more similar to the target peer in the vignette will view that peer more positively than adolescents who do not perceive themselves as similar to the target peer described in the vignette.* Perceived similarity suggests that a rater perceived the other person as having common interests or traits, which would result in more favorable ratings. In addition, perceived similarity can also increases a person's empathy and lead one to rate the person more favorably.

Demographic Characteristics

13. *Compared to minority youth, Caucasian youth will have the most positive attitudes toward peers who attend counseling.* Research indicates that ethnic minorities, and African-American youth in particular, tend to seek formal help less frequently, wait until problems are more severe before seeking help, and rely more on informal sources of help (McMiller & Weisz, 1996; Padgett et al., 1994; Schonert-Reichl et al., 1995). Consequently, ethnic minority youth are expected to view peers who attend counseling less favorably.
14. *Older adolescents will view peers with emotional and behavioral problems or who participate in counseling more favorably than younger adolescents.* Older children

have a better understanding of emotional and behavioral disorders given their increasing cognitive maturity, entry into formal operations stage, and decreased egocentrism (Coie & Pennington, 1976; Dollinger, Thelen, & Walsh, 1980; Sigelman & Mansfield, 1992). Likewise, they are better able to appreciate others' perspectives and understand causes of disorders. As a consequence, it is expected that older adolescents will hold more favorable views of peers with emotional and behavioral problems. The literature also suggests that adolescents are also able to understand better the risks and benefits of counseling better than children (Kaser Boyd et al., 1985). Consequently, older adolescents may view peers who participate in counseling more favorably than younger adolescents.

15. *Compared to adolescents who live "in town," adolescents who live "in the country" will have less favorable views toward peers who participate in counseling.* The stigma associated with mental health treatment appears to be more prevalent in rural areas (Berry & Davis, 1978; Kenkel, 1986). Conceptions of mental health problems and treatment tend to be associated with more severe forms of mental illness, such as schizophrenia, and residents of rural areas tend to be less familiar with therapy as a means of coping with less severe emotional and behavioral problems. Consequently, it is expected that adolescents living in more rural areas would view peers who participate in therapy less favorably than youth living in town.

METHOD

Experimental Conditions

The independent variables manipulated in this study included type of emotional and behavioral problem (depression, conduct disorder, family conflict, no problems) and counseling status (attending counseling vs. not attending counseling). Given that the previous literature suggests gender differences related to help-seeking and prevalence rates for certain disorders, gender was also as included an independent variable. Vignettes (see Appendix A) were modeled after vignettes previously used with elementary and middle school youth (e.g., Morgan & Wisely, 1996). All vignettes began with information introducing the peer as a new student in school and providing other non-specific information. Michael and Erica were chosen as the names of the peers in the vignettes since both names can be found among the primary ethnic populations of the school (i.e., Caucasian and African-American). All vignettes, except the ones in which the target peer did not have an emotional and behavioral problem, then described the peer as missing school a lot recently and having his or her grades go down, which could be potential outcomes for any of the emotional and behavioral problems. The outcome information was standardized in an attempt to approximate severity across problem conditions. Finally, specific information about emotional and behavioral problems and counseling status was included in the vignette (except for the vignette without emotional and behavioral problems).

Information presented in the vignettes described one of three types of emotional and behavioral problems: conduct disorder, depression, and family conflict, or no problems. The three types of problems selected are among the most common emotional and behavioral problems experienced by adolescents (Dubow et al., 1990; Kashani et al., 1987; Whitaker et al., 1990) and are among those encountered frequently in the school's mental health service program (Danda, Evans, Rey, & Nitzberg, 2000). Reviews of DSM-IV criteria, clinical case studies, and clinical experience provided the basis for the behavioral descriptions of each of the emotional and behavioral problems. Descriptions for each problem type contained approximately four behaviors consistent with common and easily observed symptoms of that problem. Vignettes with descriptions of emotional and behavioral problems were then presented to two psychologists and four advanced graduate students in order to ensure validity of the symptom descriptions. All raters independently and successfully identified each of the emotional and behavioral problem conditions described in the vignette (i.e., depression, conduct disorder, family conflict), indicating that the behavioral descriptions used in the vignettes accurately depicted the behavioral manifestations of each of the emotional and behavioral problem types targeted in this study.

Information in the vignettes also varied according to whether the target adolescent attended counseling with a psychologist who worked at their school. The term "counseling" was employed rather than therapy to be more consistent with common terminology, as indicated by school personnel. At the same time, the wording "with a psychologist" was included in order to differentiate the nature of mental health counseling from other forms of counseling (e.g., guidance counseling). Finally, the

phrase "who works at your school" was included to reflect the growing numbers of psychologists offering mental health services within the school setting, including the school district in which this study took place.

Measures

Dependent Measures

Attitudes

The Adjective Checklist (Siperstein, 1980; Siperstein & Gottlieb, 1977) assesses children's judgments of the attributes toward an actual or hypothetical peer (see Appendix B). The measure includes 32 adjectives, half of which are negative and half of which are positive. Subjects circle as many or as few of the adjectives they feel best describe the target child. The original Adjective Checklist included the adjective "handsome", which was changed to "good-looking" in order to use terminology more applicable to both genders.

Scores are obtained by subtracting the negative adjectives from the positive adjectives and adding a constant of 20 in order to eliminate negative scores (Friedrich, Morgan, & Devine, 1996; Siperstein, 1980). Siperstein (1980) suggested that scores below 20 represent an overall negative evaluation of the target child since more negative than positive adjectives were chosen as descriptors, while scores over 20 represent an overall positive evaluation of the target child since more positive than negative adjectives were chosen as descriptors. The measure has been used extensively to assess school-age children's attitudes about peers with mental retardation and physical handicaps (e.g., Bak & Siperstein, 1986; Gottlieb & Gottlieb, 1977; Morgan & Wisely, 1996; Siperstein & Gottlieb, 1977; Wisely & Morgan, 1981). Factor analysis has confirmed the construct

validity of the positive and negative valences of the adjectives, and the measure has demonstrated good internal consistency reliability (Cronbach's alpha = .81; Siperstein, 1980).

Behavioral intentions

The Adolescent Activity Preference List was based on the Activity Preference Scale (Siperstein, 1980; see Appendix C), which was designed to assess children's behavioral intentions toward an actual or hypothetical peer. The participant rates how willing they are to engage in a variety of common social activities with a target child. The original Activity Preference List contained 30 items that were derived from a list of activities generated by middle and upper elementary school youth. A shorter, 15-item version demonstrated excellent reliability (Cronbach's alpha = .90; Siperstein, 1980). Similar activity preference measures have been used with elementary and middle school children to measure attitudes towards physically or mentally handicapped children (e.g., (Bak & Siperstein, 1986; Morgan & Wisely, 1996; Wisely & Morgan, 1981).

A new Adolescent Activity Preference List (see Appendix D) was developed to include more developmentally and geographically appropriate items. The original 30 items from the Activity Preference Scale plus 13 new items were pilot tested with three adolescents (two males, one female) who rated the appropriateness of the activity, indicated the frequency of occurrence for the list of activities, and provided comments about the activities listed. Items that were consistently rated as occurring frequently (e.g., daily or once a week by at least 2 of the 3 pilot respondents) and deemed developmentally appropriate were retained for the new scale. The final version of the Adolescent Activity Preference List included 19 items. Responses are rated on a 4-point

scale, anchored by the following phrases: like a lot, like, dislike, and dislike a lot. Higher scores indicate less willingness to participate in activities with the target peer.

Manipulation check

Five true-false questions were presented after the vignette to assess accurate encoding of information about independent variables manipulated and to provide a cursory indication of reading comprehension (see Appendix E). The first two questions pertained to basic information present in all vignettes. The next three questions pertained to behavioral indicators of the emotional and behavioral problem and counseling status, and varied according to the vignette. In order to be retained in the study analyses, participants had to correctly answer at least 2 of the 3 questions related to the experimental manipulation and correctly answer at least 3 of the 5 total questions.

Respondent Characteristics

Help seeking

The Help Seeking Scale (Garland & Zigler, 1994) is a 26-item measure designed to assess children's and adolescent's attitudes willingness to seek help for psychosocial problems from adults in the school setting (See Appendix F). The measure was modeled after the Attitudes Towards Seeking Professional Help Scale (Fischer & Turner, 1970) and Propensity to Seek Help Scale (Kessler, Reuter, & Greenley, 1979, as cited in Garland & Zigler, 1994), which were both designed to measure adult attitudes. In order to assess attitudes toward seeking professional help more accurately, the word "teacher" was replaced with "therapist". Scores range from 26 to 94, with higher scores indicating more positive attitudes towards seeking help for emotional and behavioral problems. The measure has demonstrated good internal consistency (.80- .85) and test-retest reliability

(.81 - .89) (Garland & Zigler, 1994). Items asking about actual and prior help-seeking are not scored in the total.

Prior experience with therapy/counseling

One question, "Have you ever talked to a therapist or counselor about a personal or emotional problem?" regarding the individual's prior experience with help-seeking was already included as part of the Help Seeking Scale. In order to provide a broader definition of previous exposure to counseling/therapy, two additional questions were added: Has a family member or relative ever talked to a therapist or counselor about a personal or emotional problem?; Has one of your friends ever talked to a therapist or counselor about a personal or emotional problem?"

Social desirability

The Help Seeking Scale included five yes/no items from the Minnesota Multiphasic Personality Inventory (MMPI) that assess social desirability. Given the possibility of social desirability influence in attitude research, these items were retained for use in analyses. A composite score was generated by coding "1" for socially-desirable responses and "0" for non-socially desirable responses and then by summing the items to form a scale. Higher scores indicate greater social desirability.

Perceived similarity

Adolescents were asked to rate how much the person in the vignette was like him or her. Responses were based on a 4-point scale, anchored by the phrases not at all like me, not much like me, somewhat like me, and very much like me.

Demographics

Participants were asked to list their age, grade, ethnicity, and gender at the beginning of the Help-Seeking Scale. In addition, participants were asked to indicate whether they lived "in town" or "in the country" in order to provide a measure of rurality.

Procedure

Given the age of the participants, anonymous nature of the study, and survey procedure, the Institutional Review Board granted the study exempt status (i.e., completion of questionnaires indicated consent to participate). After subsequent approval from the local school board and principal, 20 classrooms were randomly chosen to participate in the study. Math and English classes were excluded from randomization at the request of school personnel. Randomization of classrooms was completed in blocks according to grade level to increase the likelihood of equal distribution of experimental conditions across grade level. However, many classrooms available for participation in the study contained students in multiple grade levels, and no classrooms contained exclusively 12^{th} graders. No information was available at the time about the gender distribution of the classrooms. The number of classrooms selected was ultimately determined by the number of students needed (approximately 500) to ensure adequate power for the proposed analyses.

During a faculty meeting, the principal investigator (C.E.D.) described the study and notified teachers whose classrooms were selected for data collection. All teachers agreed to participate; however, two classrooms were unavailable on the day of data collection. One class could not participate due to a previously planned activity and agreed to have data collected the following week. The other class was misidentified as meeting

during the class period designated for data collection, so no further data could be gathered.

Two weeks before the anticipated day of data collection, a letter to the student's parents (see Appendix G) that explained the study was sent home with each student who attended a class designated for data collection. Only one parent requested that her child not participate, and this student worked quietly at his/her desk while other students completed the study questionnaires.

Trained research assistants administered questionnaire packets and provided verbal instructions to all students in participating classrooms. Questionnaire packets also included a cover sheet (see Appendix H) explaining the study and emphasizing voluntary participation along with one vignette and the remaining questionnaires. Questionnaire completion was voluntary and anonymous (i.e., no identifying information was collected), and students who did not wish to participate were allowed to work quietly at their desks. After students turned in their completed packets, students received a debriefing statement (see Appendix I) that explained the purpose of the study in more detail and provided contact information should they have questions or concerns.

Each student received a questionnaire packet with one of 8 vignette descriptions about a hypothetical new student who was the same gender as the student. The gender of the target peer in the vignette was matched to the gender of the respondent, and packets were color-coded for ease of administration (i.e., males received blue packets that contained a vignette with a male target peer, and females received green packets that contained a vignette with a female target peer). Each of the 8 conditions (Emotional and Behavioral Problem x Counseling Status) was sequentially distributed to students within

each gender to ensure equal sample sizes across conditions. Thus, each student only answered questions about one vignette in which the peer was the same gender as the student. The first two questionnaires, which related to the vignette specifically, were counterbalanced to avoid order effects.

Participants

Participants were 453 adolescents attending grades 9-12 at Columbia High School (CHS), which is located in a rural county of north Florida. Of the 453 packets returned, six were deleted from analyses due to missing or invalid data, and five were deleted due to incorrect responses on the manipulation check, leaving a total of 442 participants in the study. No formal data was collected regarding blank packets returned (indicating refusal of the adolescent to participate), but it appeared that only a few adolescents per class did not participate.

Table 1 lists the demographic characteristics of the sample. Participants included significantly more females than males (χ^2 (1) = 7.61, $p < .001$). The gender distribution (48% males and 52% females) for 10-12th graders for the CHS 1999-2000 school year suggests that females may be slightly over-represented in this sample. Significantly more Caucasian than minority students participated (χ^2 (1) = 65.06, $p < .001$); however, the racial distribution within the sample is roughly equivalent to the current racial distribution within the high schools (70% Caucasian and 25% African-American). Significantly fewer 12th graders participated in the study relative to other grade levels (χ^2 (3, 439) = 48.17, $p < .001$). The small percentage of 12th graders in the study likely reflects the lack of classes containing exclusively 12th graders. Slight differences related to rurality also emerged [χ^2 (1,441) = 3.27, $p = .07$)], with a little over one-third of

students characterizing themselves as living in town, while almost half of the students characterized themselves as living in the country. However, approximately one-fifth of students did not answer this question. Due to concerns about the students' ability to report about their socioeconomic status, participants did not respond to any questions about their family's income or professional background. Data from the Columbia County School District reported that 52% of students are eligible for free or reduced lunches, suggesting that at least half the students in this school district are in a lower socioeconomic bracket.

Table 2 presents the sample size across the experimental conditions. Chi-square analyses revealed that despite gender differences in overall response rate, the proportion of males and females was equally distributed among the counseling status [χ^2 (1) = 1.45, p = .23)] and type of emotional and behavioral problem [χ^2 (3) = .411, p = .94)] conditions. Further chi-square analyses revealed that each of the 8 conditions across gender contained relatively equal proportions of students [χ^2 (15) = 12.59, p = .63)], with no significant differences across ethnic [χ^2 (15) = 10.94, p = .76)], grade [χ^2 (45) = 32.92, p = .91)], or rural [χ^2 (15) = 18.97, p = .21)] distributions.

Table 1. Demographic Characteristics of Participants (N=442).

	Frequency	Percentage
Gender		
Male	192	43.4%
Female	250	57.6%
Ethnicity		
Caucasian	304	68.8%
African-American	96	21.7%
Other	49	8.9%
Missing Data	3	0.6%
Rurality		
Living in town	160	36.2%
Living in the country	194	43.9%
Missing Data	88	19.9%
Grade		
9	120	27.1%
10	108	24.4%
11	155	35.1%
12	54	12.2%
Missing Data	5	1.2%

Table 2. Subject Distribution across Experimental Conditions.

	Counseling		No Counseling		
Emotional and Behavioral Problem	Male	Female	Male	Female	Total
No Problem	23	33	27	29	112
Depression	29	32	20	33	114
Conduct Disorder	25	28	19	35	107
Family Conflict	27	28	22	32	109
Total	104	121	88	129	442

ANALYSIS PLAN

Questionnaires were visually inspected to detect random responding, and participants with random responses or who failed the manipulation check were deleted from all analyses. Psychometric properties were examined for each of the dependent measures. For this study, an individual's scores on the Adolescent Activity Preference List and the Help Seeking Scale were calculated by summing across all items the individual completed and dividing this total by the number of items that individual completed. In this way, calculation of the total score takes into account missing data as well as yields a more interpretable total score (i.e., scores correspond to valences attributed to the anchor phrases for each of the 4 points). In order to determine whether students answered in a socially-desirable manner, correlations between social desirability and the dependent measures were generated; if social desirability correlated with either dependent measure, it was to be analyzed as a covariate in subsequent analyses. Correlations respondent and demographic characteristics were also examined.

A 4 (Emotional and Behavioral Problem Type) x 2 (Counseling Status) x 2 (Gender of Target Peer/Respondent) ANOVA was conducted to determine main and interaction effects of the experimental conditions and gender. Analyses were conducted separately for each of the two dependent measures: the Adjective Checklist and the Adolescent Activity Preference List: Adjective checklists tap into a primarily cognitive component (internalized ideas and evaluation), whereas measures of behavioral intentions

tap into a primarily connotative component (behavioral commitment) (Gottlieb & Gottlieb, 1977). Several studies using similar measures have also found stronger effects for the adjective checklist as well as small to insignificant correlations between adjective checklists and measures of behavioral intentions (Siperstein & Gottlieb, 1977; Wisely & Morgan, 1981). In light of this previous research, it was hypothesized that the Adjective Checklist would produce more significant and stronger effects than the Adolescent Activity Preference List.

Significant univariate main effects and interactions were followed up by multiple comparisons. Given the number of multiple comparisons, Sidak's test was employed to control for experimentwise error. The Sidak test $[1 - (1 - \alpha_e)^{1/N}]$ is similar to the Bonferroni correction, in that the alpha is adjusted for the number of tests performed, but tends to be less stringent.

Secondary analyses included variables related to respondent characteristics (i.e., Prior Counseling Experience with counseling/therapy, Help Seeking attitudes, and Similarity to target adolescent) and demographic variables (i.e., Ethnicity, Grade level, and Rurality). In order to determine the impact of these variables as related to the experimental conditions, each of the six variables was added separately and independently to the primary ANOVA model (i.e., Emotional and Behavioral Problems, Counseling Status, and Gender). Again, a separate ANOVA was conducted for each of the dependent variables with significant univariate main effects and interactions followed up by multiple comparisons, using Sidak's test to control for experimentwise error.

In order to maximize sample sizes across the experimental conditions, several levels of the variables used in the secondary analyses were combined. For Prior

Counseling Experience, two variables were created—one involving a composite yes/no variable based on an endorsement of any one of the three questions related to prior experience (self, family, or friend) and the other involving the single question asking if the adolescent had talked to a therapist or counselor about a personal or emotional problem. Analyses were run with the composite Prior Experience variable first, with the plan that if no significant effects emerged, the single question Prior Experience variable would be utilized. For the purposes of the ANOVA analyses, help seeking attitudes were categorized as "Favorable" or "Unfavorable" based on their total score. Since values up to 3.00 corresponded with the negative valence of "disagreeing" with a statement, all total scores up to 3.00 were considered "Unfavorable" attitudes. Likewise, scores greater than 3.00 were considered "Favorable" since they corresponded the positive valence of "agreeing" with a statement. As for the similarity to target adolescent in the vignette, scores of 1 or 2 (not at all like me, not much like me) were grouped as "Not Similar" and scores of 3 and 4 (somewhat like me, very much like me) were grouped as "Similar." Given the small sample size of other minorities relative to African-American and Caucasian groups, only the latter two groups were included in analyses related to ethnicity.

RESULTS

Data Inspection

Questionnaires that had greater than 20% of items missing were considered invalid, but participants were retained if they had completed at least one of the dependent measures (the Adjective Checklist or the Adolescent Activity Preference List) sufficiently. Six packets that had suspect or invalid data were removed (e.g., circled female but completed male version of questionnaire, did not complete either dependent measures sufficiently, or created own categories and made inappropriate comments). Five additional questionnaires were removed due to a failure to answer enough manipulation items correctly. As a result of deletion of invalid or suspect data, 442 (97.6%) of the original 453 participants were available for subsequent analyses.

Of the 442 participants, nine participants (2.4%) either did not complete the Adolescent Activity Preference List or were deleted from subsequent analyses for that measure due to excessive missing data. Of the remaining 433 valid Adolescent Activity Preference List questionnaires, thirty (6.9%) had 3 or fewer items missing and were included in subsequent analyses. On the Adjective Checklist, fourteen participants (3.1%) did not complete the questionnaire, leaving a total of 428 valid questionnaires for use in analyses involving that measure. On the Help Seeking Scale, eleven participants (2.5%) did not complete the measure or were deleted from subsequent analyses due to excessive missing data. Of the remaining 431 valid Help Seeking Scale questionnaires, 34 (7.9%)

had 3 or fewer items missing and were included in subsequent analyses. The scoring of the Adolescent Activity Preference List and the Help Seeking Scale allowed for imputation of missing data through summing the total for each participant and dividing the total score by the number of items answered.

Examination of the frequencies and distributions of the dependent measures identified five outliers (i.e., scores beyond 3 standard deviations from the mean) on the Adjective Checklist and one outlier on the Help Seeking Scale. These scores fell along the continuum of scores in the distribution (i.e., there were no significant gaps between the outliers and the rest of the scores). Further, visual inspection of these participants' response patterns on other questionnaires revealed no other anomalies. As such, these individuals' scores were not considered invalid outliers and were retained in subsequent analyses.

Psychometric Analyses

Histograms of the frequency of participants' scores on the dependent measures as well as the Help Seeking Scale suggested that the distributions of these measures followed a normal curve. In addition, measures of skewness (i.e., symmetry of distribution) and kurtosis (i.e., peakedness or flatness of distribution) were all within the ±1 range, further supporting the presence of a normal distribution across these measures. Item-total correlations and alpha reliability coefficients were calculated for each dependent measure and the Help Seeking Scale. Internal consistency of the dependent measures ranged from adequate on the Adjective Checklist ($\alpha = .75$) to excellent on the Adolescent Activity Preference List ($\alpha = .96$), and were consistent with findings from previous literature (Siperstein, 1980). The Help Seeking Scale also demonstrated good

internal consistency (α = .85), consistent with previous literature (Garland & Zigler, 1994). On the other hand, the 5 items comprising the social desirability scale demonstrated poor internal consistency (α = .35), suggesting that items did not reliably assess social desirability. However, the mean score for social desirability items was to .71 (SD = .91), with a median and mode of 0, indicating that participants generally did not answer in a socially desirable manner. Since few respondents endorsed any of the items in a socially-desirable manner, it is likely that there was random scatter across items endorsed in a socially-desirable manner may account for the poor reliability of the scale.

Descriptive Statistics

Scores on the Adjective Checklist ranged from 4.0 to 36.0 (higher scores indicate more positive attitudes toward the target peer), with an average of 19.41 (SD = 5.75). Scores above 20 indicate overall favorable attitudes, and scores below 20 indicate overall unfavorable attitudes. Scores on the Adolescent Activity Preference List ranged from 1.0 to 4.0 (higher scores indicate lower acceptance), with an average score 2.31 (SD = .58). Tables 3 and 4 present the means and standard deviations for the Adjective Checklist and the Adolescent Activity Preference List, respectively, for each of the 8 conditions across gender. The Adjective Checklist and the Adolescent Activity Preference List were somewhat correlated (r = -.36, $p < .001$), indicating that as perceptions of the target peer improved, willingness to engage in activities with the target peer also improved slightly. Correlations between social desirability and the dependent measures were not significant (Adjective Checklist, r = .007, p = .89; Adolescent Activity Preference List, r = .03, p = .50), so social desirability was not included as a covariate in subsequent analyses.

Pearson correlations between the six respondent and demographic variables revealed only one significant correlation (Similarity and Help Seeking; $r = -.15$; $p < .002$).

Table 5 presents respondent characteristics of the participants. With respect to Perceived Similarity, only 28.5% of the adolescents viewed themselves as similar to the target adolescent described in the vignettes. Significantly fewer adolescents (20% vs. 54%) viewed themselves as similar to the target peers described with an emotional and behavioral problems as compared to the target peer without any problems [$\chi^2 (1) = 46.24$, $p < .001$)]. Sixty-one percent of the sample reported having sought help from a counselor or therapist themselves and/or knowing someone who had sought such help, with approximately one-quarter of the sample reported having sought help in the past themselves. There were no gender differences related to prior counseling experience or perceived similarity to the target peer.

Scores on the Help-Seeking Scale ranged from 1.39 to 3.83, with an average of 2.76 ($SD = .40$). Thus, adolescents' views of help seeking in this sample were slightly unfavorable but approached favorable ratings (i.e., score greater than 3.0). Females had significantly higher help-seeking scores ($M = 2.83$) than males ($M = 2.66$) [$F (1, 429) = 19.52$; $p < .001$]. When scores on the Help Seeking Scale were categorized as Favorable vs. Unfavorable (for the purposes of the ANOVA analysis), 69% of scores fell within the unfavorable attitudes category. Again, a significantly higher proportion of females (75% vs. 25%) had favorable attitudes relative to males [$\chi^2 (1, 430) = 21.72$, $p < .001$)]. When asked to endorse any individual, to whom they would turn if sad or upset, adolescents overwhelmingly endorsed friends (86%) and parents (52%). Two-fifths of the sample would turn to a sibling, and 28% would turn to another adult. Only 10% and 6% would

seek out a teacher or counselor, respectively, if sad or upset. Finally, 15% indicated that they might not seek help from any one.

Primary ANOVA Analyses

Results of the ANOVA for the Adjective Checklist revealed that the 4 (Emotional and Behavioral Problems) x 2 (Counseling Status) x 2 (Gender of Respondent/Target Peer) model reached significance [F (15, 412) = 25.21, $p < .001$, $\varepsilon^2 = .48$]. Likewise, the same ANOVA model for the Adolescent Activity Preference List reached significance [F (15, 417) = 8.49, $p < .001$, $\varepsilon^2 = .23$]. Main effects and interactions are described below.

Main Effects

Emotional and Behavioral Problem

A significant main effect for emotional and behavioral problems, which corresponded to Hypotheses 1 and 2, emerged on both the Adjective Checklist [F (3, 412) = 102.05, $p < .001$, $\varepsilon^2 = .43$] and Adolescent Activity Preference List [F (3, 417) = 19.28, $p < .001$, $\varepsilon^2 = .12$]. Multiple comparison analyses revealed full support for Hypothesis 1 (i.e., adolescents would view peers with emotional and behavioral problems more negatively than peers without such problems) on the Adjective Checklist, but only partial support for Hypothesis 1 on the Adolescent Activity Preference List. Means for each dependent measure are presented in Table 6.

On the Adjective Checklist, as seen in Figure 1, adolescents rated target peers in the No Problem condition (M = 25.26) significantly more positively than target peers in the three emotional and behavioral problem conditions: Depression (M = 17.63; $p < .001$; ES = .60), Conduct Disorder (M = 15.52; $p < .001$; ES = .73), and Family Conflict (M =

18.67; $p < .001$; ES = .59). Further, target peers described as having emotional or behavioral problems obtained average scores less than 20, indicating that more negative than positive adjectives were chosen as descriptors (i.e., an overall unfavorable attitude). In contrast, target peers described as not exhibiting symptoms of emotional and behavioral problems obtained average scores greater than 20, indicating that more positive than negative adjectives were chosen as descriptors (i.e., an overall favorable attitude). On the Adolescent Activity Preference List, slightly different findings emerged. As seen in Figure 2, adolescents' responses indicated a significantly higher willingness to participate in activities with peers in the No Problem condition (M = 2.29) compared to the Conduct Disorder condition (M = 2.67; $p < .001$; ES = .33). The No Problem condition did not differ from the Depression or Family Conflict conditions.

Multiple comparison analyses further revealed full support for Hypothesis 2 (i.e., peers in the Conduct Disorder condition would be viewed more negatively than peers in the other two emotional and behavioral problem conditions) for both dependent measures. As predicted, target peers in the Conduct Disorder were rated significantly more negatively than target peers in the Depression ($p < .002$; ES = .25) or Family Conflict ($p < .001$; ES = .40) condition on the Adjective Checklist. Likewise, adolescents were significantly more willing to engage in activities with target peers in the Depression (M = 2.20; $p < .001$; ES = .38) and Family Conflict (M = 2.20; $p < .001$; ES = .39) conditions relative to peers in the Conduct Disorder condition (M = 2.67).

In sum, a main effect for Emotional and Behavioral Problems versus No Problems was shown only for the Adjective Checklist (Hypothesis 1); however, adolescents

consistently rated peers with Conduct Disorder the least favorably and were least willing to participate in activities with them (Hypothesis 2).

Counseling Status

Analyses revealed no significant main effects for Counseling Status [F (1, 412) = .047, p = .828] on the Adjective Checklist or the Adolescent Activity Preference List [F (1, 417) = .068, p = .794].

Gender of Respondent/Target Peer

Although not predicted, a significant main effect emerged for Gender on the Adjective Checklist [F (1, 412) = 22.64, $p < .001$, $\varepsilon^2 = .05$] and the Adolescent Activity Preference List [F (1, 417) = 55.82, $p < .001$, $\varepsilon^2 = .12$]. On the Adjective Checklist, females (M = 20.26) rated same-sex peers in all vignettes significantly more positively than males rated their same-sex peers (M = 18.28; $p < .001$; ES = .14). Similarly, females (M = 2.14) were significantly more willing than males (M = 2.53; $p < .001$; ES = .32) to participate in the activities enumerated on the Adolescent Activity Preference List with their same-sex peers. Thus, females in this study generally tended to describe their same-sex peers more positively than males and were more willing to engage in activities with these peers than males.

Interactions

Emotional and Behavioral Problem x Counseling Status

A significant Emotional and Behavioral Problem x Counseling Status interaction effect, which corresponded to Hypotheses 3 through 6, emerged on the Adjective Checklist [F (3, 412) = 4.812, $p < .003$, $\varepsilon^2 = .03$], but not on the Adolescent Activity

Preference List [F (3, 417) = .053, p = .984]. Estimated marginal means on the Adjective Checklist for the Emotional and Behavioral Problem x Counseling Status interaction are listed in Table 7 and depicted in Figure 3. Results of multiple comparison analyses revealed full support for Hypothesis 3 (i.e., for peers with no apparent emotional and behavioral problems, those who participated in counseling would be viewed less favorably as compared to those who did not participate in counseling). Specifically, target peers in the No Problem, Counseling condition (M = 23.99) received significantly lower ratings than target peers in the No Problem, No Counseling condition (M = 26.53 , $p <$ .002). Notably, ratings of target peers described with an emotional and behavioral problem remained, on average, below 20 (i.e., an overall unfavorable attitude), whereas, target peers described without a emotional and behavioral problems averaged higher than 20 (i.e., an overall favorable attitude), regardless of counseling status. Further, examination of effect sizes associated with decreases in attitudes suggested that the effects of counseling status (ES = .21) was not as strong as the overall effect of having an emotional and behavioral problem (ES = .64).

Hypothesis 4 (i.e., among peers with emotional and behavioral problems, those who were in counseling would be viewed more favorably than those who were not in counseling) and Hypothesis 5 (i.e., differences between ratings of peers in counseling would differ based on the type of emotional and behavioral problem) received little support. Although differences between ratings of target peers with Conduct Disorder in the No Counseling condition (M = 14.79) and Counseling condition (M = 16.26) were in the expected direction and approached significance (p = .087; ES = .17). At the same time, the small increase in attitudes toward peers with conduct disorder who attended

counseling did not greatly improve their ratings relative to peers in the Depression (M = 18.18; p = .11; ES = .22). and Family Conflict.(M = 18.83; p < .01; ES = .35) conditions. Thus, there was little overall change in attitudes toward peers with emotional and behavioral problems associated with counseling (Hypothesis 5).

Hypothesis 6 (i.e. for adolescents participating in counseling, those who had obvious emotional and behavioral problems would be viewed more favorably than peers who did not have obvious emotional and behavioral problems) did not receive support. Attending counseling neither greatly improved that status of target peers with emotional and behavioral problems, nor greatly lessened the status of target peers without apparent symptoms of emotional and behavioral problems.

Gender x Emotional and Behavioral Problem

A significant Emotional and Behavioral Problems x Gender interaction effect, which corresponded to Hypothesis 7, emerged on the Adjective Checklist [F (3, 412) = 3.43, p < .02, ε^2 = .02], but not on the Adolescent Activity Preference List [F (1, 412) = .126, p = .723]. Multiple comparison analyses revealed full support for Hypothesis 7 for females (i.e., females would view same-sex peers with Conduct Disorder most negatively) but only partial support for males (i.e., males would view same-sex peers with Depression most negatively). Estimated marginal means on the Adjective Checklist for the Emotional and Behavioral Problems x Gender interaction are listed in Table 8 and depicted in Figure 4.

As expected, females rated same-sex peers in the Conduct Disorder condition (M = 15.72) significantly lower than same-sex peers in either the Depression (M = 19.04; p < .001; ES = .37) or Family Conflict (M = 19.17; p < .001; ES = .47) conditions. In partial

support of Hypothesis 7, males rated same-sex peers in the Depression condition ($\underline{M}$ = 16.21) significantly lower than same-sex peers in the Family Conflict ($\underline{M}$ = 18.18; $\underline{p}$ < .001; $\underline{ES}$ = .25), but not the Conduct Disorder ($\underline{M}$ = 15.32) condition. Unexpectedly, male targets in the Conduct Disorder condition were rated significantly lower than male targets in the Family Conflict condition ($\underline{p}$ < .001; $\underline{ES}$ = .32) but did not differ significantly from male targets in the Depression condition. The interaction described above was likely facilitated by the fact that females rated their same-sex peers with Depression ($\underline{M}$ = 19.03) significantly higher relative to males ($\underline{M}$ = 16.21, $\underline{p}$ < .001; $\underline{ES}$ = .30). Contrary to expectations, no such gender effect emerged for the peers in the Conduct Disorder condition.

Gender x Counseling Status

No significant Gender x Counseling Status interaction effect, which corresponded to Hypothesis 8, emerged on either the Adjective Checklist [$\underline{F}$ (1, 412) = .126, $\underline{p}$ = .723] or the Adolescent Activity Preference List [$\underline{F}$ (1, 417) = .027, $\underline{p}$ = .868]. Thus, no evidence was found suggesting that females view same-sex peers in counseling more positively than males.

Emotional and Behavioral Problem x Counseling Status x Gender.

A significant Emotional and Behavioral Problem x Counseling Status x Gender interaction effect, which corresponded to Hypothesis 9, emerged on the Adjective Checklist [$\underline{F}$ (3, 412) = 3.124, $\underline{p}$ < .03, $\underline{\varepsilon}^2$= .02] but not on the Adolescent Activity Preference List [$\underline{F}$ (3, 417) = 1.97, $\underline{p}$ = .119]. Means and Standard Deviations for all conditions are presented in Table 1. The means are graphed depicted in Figure 5. Multiple comparisons revealed partial support for Hypothesis 9 (i.e., males would view

same-sex peers with depression who attend counseling most negatively, whereas females would view same-sex peers with depression who attend counseling most positively).

Specifically, males tended to view same-sex peers in the Conduct Disorder and Family Conflict conditions slightly more positively in the Counseling condition relative to the No Counseling condition ($p = .06$; ES = .31 and .19; ES = .20, respectively). No significant effect was observed for male target peers in the Conduct Disorder condition. As a result, males did not rate their same-sex peers in the Depression, Counseling condition the lowest of all conditions as predicted. Rather, males rated same-sex peers in the Counseling condition significantly lower in the Depression condition as compared to the Family Conflict condition ($p < .04$; ES = .40), but relatively equivalent to those in the Conduct Disorder condition (ES = .05), thereby providing only partial support for the first part of Hypothesis 9.

As expected, females rated same-sex peers in the Depression condition , significantly higher in the Counseling condition as compared to the No Counseling condition ($p < .005$; ES = .30). Likewise, within the Counseling condition, female targets in the Depression condition were rated significantly more positively than in the Conduct Disorder condition ($p < .001$; ES = .46), and moderately more positively in the Family Conflict condition ($p = .10$; ES = .21), supporting the second half of Hypothesis 9. Notably, female target peers in the Depression, Counseling condition obtained scores slightly higher than 20, indicating an overall favorable attitudes from female respondents—one of the few times that peers with an emotional and behavioral problem were viewed favorably overall.

In sum, Hypothesis 9 was fully supported relative to females but only partially supported relative to males. Males and females had significantly stronger and opposite reactions to their same-sex peers with depression, depending on counseling status. Specifically, females viewed their same-sex peers with depression in counseling most positively, and males viewed their same-sex peers with depression less positively relative to those with family conflict but not conduct disorder.

Secondary ANOVA Analyses

Prior Experience with Counseling/Counseling

Hypothesis 10 postulated that adolescents who had prior experience with counseling would view peers who participated in counseling more favorably (i.e., Counseling Status x Prior Experience interaction). ANOVA analyses revealed no significant effects on either dependent measure for Prior Experience defined as a composite of having sought help in the past themselves and/or knowing someone who has sought help from a counselor or therapist. When Prior Experience was redefined to include only individuals who had themselves sought help from a therapist or counselor, several significant main effects and interactions emerged on the Adolescent Activity Preference List, but not the Adjective Checklist. Yet, neither the proposed Counseling x Prior Experience interaction that corresponded directly to Hypothesis 10 nor a three-way interaction that included Counseling and Prior Experience was significant. Thus, Hypothesis 10 was not supported. The significant main effects and interactions that were not predicted but did emerge are described below.

A significant main effect for Prior Experience emerged on the Adolescent Activity Preference List [$F(1, 392) = 21.58$, $p < .001$, $\varepsilon^2 = .05$]. Adolescents who

reported having seen a therapist or counselor in the past were significantly more willing to engage in activities with the target peer ($M = 2.13$) than adolescents who had no history of prior counseling or counseling experience ($M = 2.41$, $p < .001$).

ANOVA revealed a moderately significant Emotional and Behavioral Problem x Gender x Prior Experience interaction [$F(3, 392) = 2.58$, $p = .053$, $\varepsilon^2 = .02$] on the Adolescent Activity Preference List. Estimated marginal means for the Adolescent Activity Preference List are presented in Table 9 and depicted in Figure 6. Significant gains related to Prior Experience were found for females rating same-sex peers in the Conduct Disorder ($p < .001$) and Family Conflict ($p < .01$) conditions, but not the Depression and No Problem conditions. On the other hand, significant or nearly significant gains related to Prior Experience were found for males rating same-sex targets in the No Problem ($p = .07$), Depression ($p < .001$), and Family Conflict conditions ($p = .054$), but interestingly enough, not the Conduct Disorder condition.

The largest increases between adolescents with No Prior Experience and those with Prior Experience were found for males rating male targets with depression and females rating female targets with conduct disorder. Ultimately, these differences resulted in changes in males' and females' willingness to participate in activities among the disorders. Specifically, males with No Prior Experience remained significantly less willing to engage in activities with male targets in the Conduct Disorder condition relative to those in the Family Conflict condition ($p < .01$). The significantly large increase in status for male targets with Depression who were rated by males with Prior Experience (and lack of change for those with Conduct Disorder) resulted in males' being significantly less willing to engage in activities with male targets in the Conduct Disorder

as compared to the Depression condition ($p < .01$). Similarly, females with No Prior Experience were significantly less willing to engage in activities with female targets in the Conduct Disorder condition than those in all three other conditions: No Problem ($p < .001$), Depression ($p < .001$), or Family Conflict ($p < .001$) conditions. However, these differences disappeared for females with Prior Experience, largely accounted for by the significant increase in status for female targets with Conduct Disorder who were rated by females who had Prior Counseling experience.

Help-Seeking Attitudes

Analyses revealed no significant Counseling x Help Seeking Attitudes interaction, which corresponded to Hypothesis 11 (i.e., adolescents who had more favorable attitudes toward help seeking would view adolescent targets in counseling more positively than adolescents with unfavorable attitudes toward help seeking). However, a significant main effect emerged on the Adolescent Activity Preference List [F (1, 390) = 10.45, $p < .002$, $\varepsilon^2 = .03$]. Adolescents who had more favorable attitudes toward help seeking were significantly more willing to engage in activities with target peers ($M = 2.19$) than adolescents with unfavorable attitudes ($M = 2.41$; $p < .001$), regardless of counseling status and emotional and behavioral problems.

Similarity

A main effect for Similarity emerged on the Adjective Checklist [F (1, 396) = 4.38, $p < .04$, $\varepsilon^2 = .01$] and the Adolescent Activity Preference List [F (1, 401) = 13.31, $p < .001$, $\varepsilon^2 = .03$], which provided full support for Hypothesis 12 (i.e., adolescents who perceived themselves as similar to the target peer would rate the target peer more

favorably than adolescents who did not perceive themselves as similar to the target adolescent). Adolescents who perceived the target peer in the vignettes as Similar to themselves rated the target peer significantly higher ($\underline{M}$ = 19.45) on the Adjective Checklist than adolescents who perceived the target peer as Not Similar to them ($\underline{M}$ = 18.85; $\underline{p} < .04$). Likewise on the Adolescent Activity Preference List, adolescents who perceived the target peer in the vignettes as Similar were significantly more willing to share activities with the target peer ($\underline{M}$ = 2.18) than adolescents who perceived the target peer as Not Similar ($\underline{M}$ = 2.41; $\underline{p} < .001$).

In addition to the main effect, several significant three-way interactions emerged. Specifically, a significant Emotional and Behavioral Problems x Counseling Status x Similarity to Target interaction emerged [$\underline{F}$ (3, 396) = 2.94, $\underline{p} < .03$, $\varepsilon^2 = .02$] on the Adjective Checklist. In addition, a three-way interaction between Emotional and Behavioral Problems, Gender, and Similarity to Target approached significance [$\underline{F}$ (3, 396) = 2.33, $\underline{p} = .074$, $\varepsilon^2 = .02$] on the Adjective Checklist, and achieved significance on the Adolescent Activity Preference List [$\underline{F}$ (3, 396) = 2.73, $\underline{p} < .05$, $\varepsilon^2 = .02$].

Estimated marginal means for the Emotional and Behavioral Problems x Counseling Status x Similarity to Target on the Adjective Checklist are presented in Table 10 and graphed in Figure 7. Primarily, the effects of perceived Similarity and Counseling Status differed in the Depression condition. Specifically, if adolescents perceived the target peer in the Depression condition as Similar, they rated target peers in the No Counseling condition significantly higher ($\underline{p} < .05$), but rated target peers in the Counseling condition significantly lower ($\underline{p} < .01$). Likewise, adolescents who perceived the target peer as Not Similar rated target peers in the Depression condition significantly

higher in the Counseling condition relative to the No Counseling condition ($p < .004$). In contrast, adolescents who perceived the target peer as Similar to them rated target peers in the Depression condition significantly lower in the Counseling relative to the No Counseling condition ($p < .04$).

Estimated marginal means for the Emotional and Behavioral Problems x Gender x Similarity to Target interaction on the Adolescent Activity Preference List are presented in Table 11 and graphed in Figure 8. The primary interaction effects related to Similarity were evident in the Female, Conduct Disorder conditions and the Male, Family Conflict conditions. Females who perceived the target female as Similar were significantly more willing to engage in activities with same-sex peers in the Conduct Disorder condition ($p < .004$). Notably, the significantly lower ratings for target females in Conduct Disorder relative to the other three conditions (all $p < .003$) when target female was perceived as Not Similar disappeared if the target female was perceived as Similar. On the other hand, males who perceived themselves as Similar to the target male were moderately significantly more willing to engage in activities with target males in the Family Conflict condition ($p < .008$) and No Problem ($p = .07$) conditions.

Ethnicity

Hypothesis 14 proposed that Caucasian adolescents would view target peers in counseling more positively than ethnic minority adolescents (i.e., Ethnicity x Counseling interaction). Limitations in sample size restricted the analyses to comparisons between African-Americans and Caucasians. No significant interactions related to ethnicity and counseling emerged on either dependent measure. Thus, Hypothesis 14 was not supported.

Analyses did reveal a significant main effect for Ethnicity on the Adjective Checklist [F (1, 386) = 3.75, p = .054, ε^2 = .01], such that African-American youth gave slightly higher ratings (M = 20.07) than Caucasian youth (M = 19.03) overall. In addition, a significant Ethnicity x Emotional and Behavioral Problems interaction [F (1, 393) = 2.90, p = .09, ε^2 = .01] emerged on the Adolescent Activity Preference List. Estimated marginal means are presented in Table 12 and graphed in Figure 9. African-American youth (M = 2.05) were more willing to engage in activities with peers in the No Problem condition relative to Caucasian youth (M = 2.34; $p < .02$). In addition, multiple comparisons between the emotional and behavioral problem conditions among each ethnic group revealed slightly different patterns. For African-American youth, the pattern was similar to the pattern originally found (i.e., they were less willing to participate in activities with peers in Conduct Disorder condition relative to the other three conditions). Caucasian youth, on the other hand, were significantly more willing to participate in activities with peers in the Depression condition (M = 2.12; $p < .04$) but significantly less willing to participate in activities with peers in the Conduct Disorder condition ($p < .002$), relative to the No Problem condition. (M = 2.34). Again, peers in the Conduct Disorder condition were seen less favorably than those in the other two emotional and behavioral problem conditions ($p < .001$).

Grade Level

Hypothesis 15, which corresponded to Emotional and Behavioral Problems x Grade and Counseling Status x Grade interactions, postulated that older adolescents would view peers with emotional and behavioral problems and those who participated in counseling more favorably than younger adolescents. No significant main effects or

interactions emerged on the Adolescent Activity Preference List, and no significant main effects or two-way interactions emerged on the Adjective Checklist. However, ANOVA analyses revealed a significant Counseling Status x Gender x Grade interaction [F (3, 359) = 2.75, $p < .05$, $\varepsilon^2 = .02$] on the Adjective Checklist. Estimated marginal means are presented in Table 13. Contrary to expectations, males in 12th grade rated same-sex peers in the Counseling condition significantly lower than peers in the No Counseling condition ($p < .02$). Thus, Hypothesis 15 was not confirmed. However, given the small sample size of 12th graders in this study, this finding may be spurious and would need further replication before generalizing to other populations.

Rurality

Hypothesis 16, which corresponded to a Counseling Status x Rurality interaction, postulated that adolescents in more rural areas would have more negative views toward peers who participate in counseling. A Counseling Status x Rurality interaction emerged on the Adjective Checklist [F (1, 392) = 4.80, $p < .03$, $\varepsilon^2 = .02$], providing support for Hypothesis 16. Estimated marginal means are presented in Table 14 and graphed in Figure 10. Within the Counseling condition, adolescents who lived in Town (M = 20.29) had a moderately significant tendency to rate peers more favorably as compared to adolescents who lived in the Country (M = 19.13; p = .08). Somewhat surprisingly, adolescents who lived in Town tended to rate peers in the Counseling condition (M = 20.29) higher than peers in the No Counseling condition (M = 18.77; p = .07). Interestingly, their rating was also over 20, indicating that adolescents living in town held overall favorable attitudes of adolescents who participated in counseling. In contrast, no differences emerged related to rurality and emotional and behavioral problems.

Table 3. Means and Standard Deviations across Experimental Conditions on the Adjective Checklist (N=434)

Emotional and Behavioral Problem	No Therapy		Therapy	
	Male	Female	Male	Female
No Problem				
M	24.63	28.43	22.18	25.80
SD	4.47	4.14	7.37	3.78
Depression				
M	16.60	17.55	15.83	20.53
SD	4.60	4.29	3.90	5.27
Conduct Disorder				
M	14.06	15.51	16.59	15.93
SD	3.62	3.15	4.24	3.37
Family Conflict				
M	17.37	19.67	19.00	18.67
SD	4.65	3.61	3.23	2.99

Note. Scores range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes.

Table 4. Means and Standard Deviations across Experimental Conditions on the Adolescent Activity Preference List (N = 433)

Emotional and Behavioral Problem	No Counseling		Counseling	
	Male	Female	Male	Female
No Problem				
M	2.42	2.14	2.63	1.95
SD	.52	.41	.62	.38
Depression				
M	2.39	1.99	2.40	2.00
SD	.46	.56	.62	.55
Conduct Disorder				
M	2.83	2.46	2.83	2.56
SD	.58	.52	.51	.57
Family Conflict				
M	2.44	1.96	2.30	2.08
SD	.53	.43	.59	.44

Note. Scores range from 1 (most positive) to 4 (most negative).

Table 5. Respondent Characteristics of Participants Across Gender (N = 442).

	Frequency			Total Percentage of Sample
	Male	Female	Pearson Chi Square	
Similarity to Target Peer			.48	
Similar	58	68		28.5%
Not Similar	134	182		71.5%
Prior Experience with Counseling/Therapy			.26	
Self	49	61		24.9%
			2.28	
Self, Family, and/or Friend	112	169		61.1%
Attitude Toward Help-Seeking†			21.72*	
Favorable	31	93		28.0%
Unfavorable	152	155		69.5%

†Based on Help Seeking Score total; N = 431
*p < .001

Table 6. Means on the Adjective Checklist and Adolescent Activity Preference List for Emotional and Behavioral Problems Main Effect

Emotional and Behavioral Problem	Adjective Checklist	Adolescent Activity Preference List
No Problem	25.26	2.29
Depression	17.63	2.20
Conduct Disorder	15.52	2.67
Family Conflict	18.67	2.20

Note. Scores on the Adjective Checklist range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes. Scores on the Adolescent Activity Preference List range from 1 (most positive) to 4 (most negative).

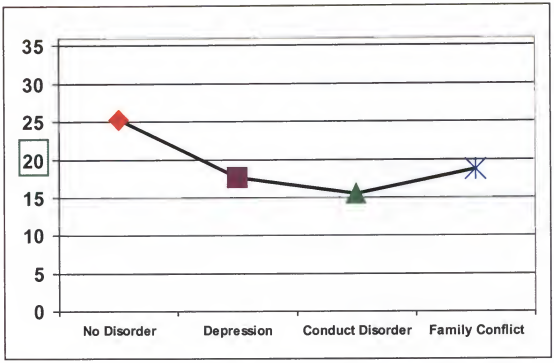

Figure 1. Main Effect of Emotional and Behavioral Problems on the Adjective Checklist

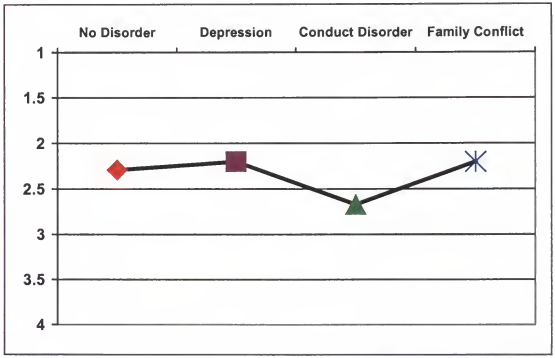

Figure 2. Main Effect for Emotional and Behavioral Problems on the Adolescent Activity Preference List

Table 7. Estimated Marginal Means on the Adjective Checklist for Emotional and Behavioral Problems x Counseling Status Interaction

Emotional and Behavioral Problem	No Counseling	Counseling
No Problem	25.53	23.99
Depression	17.01	18.18
Conduct Disorder	14.79	16.26
Family Conflict	18.51	18.83

Note. Scores range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes

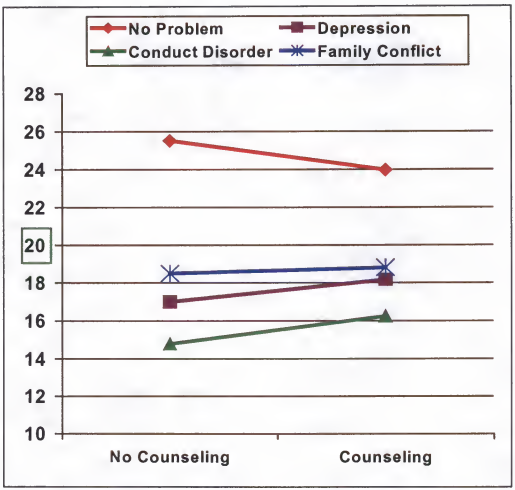

Figure 3. Interaction Effect for Emotional and Behavioral Problems x Counseling Status on the Adjective Checklist

Table 8. Estimated Marginal Means on the Adjective Checklist for Emotional and Behavioral Problems x Gender Interaction

Emotional and Behavioral Problem	Male	Female
No Problem	23.41	27.11
Depression	16.21	19.04
Conduct Disorder	15.32	15.72
Family Conflict	18.18	19.17

Note. Scores range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes

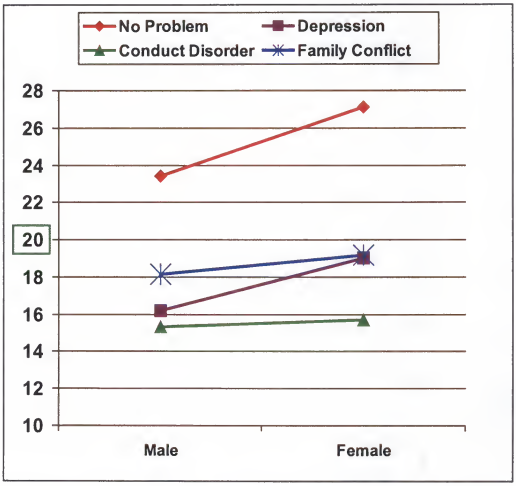

Figure 4. Interaction Effect for Emotional and Behavioral Problems x Gender on the Adjective Checklist

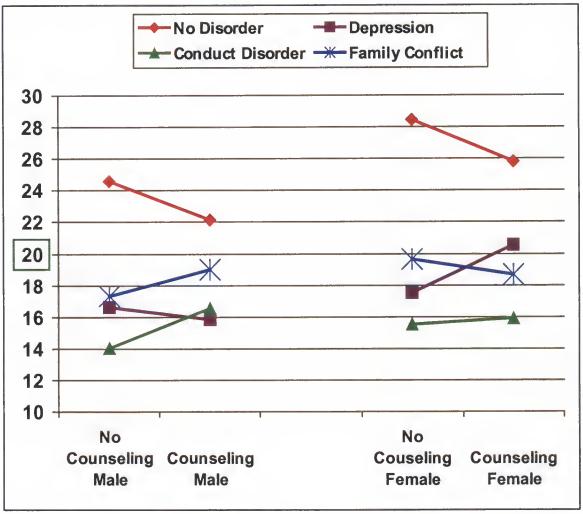

Figure 5. Interaction Effect for Emotional and Behavioral Problems x Counseling Status x Gender on the Adjective Checklist (see Table 3 for Means)

Table 9. Estimated Marginal Means on the Adolescent Activity Preference List for Emotional and Behavioral Problems x Gender x Prior Counseling Experience Interaction.

	Male		Female	
Emotional & Behavioral Problem	No Prior Experience	Prior Experience	No Prior Experience	Prior Experience
No Problem	2.63	2.33	2.05	2.02
Depression	2.56	2.05	2.00	2.00
Conduct Disorder	2.84	2.71	2.66	2.12
Family Conflict	2.46	2.10	2.11	1.72

Note. Scores range from 1 (most positive) to 4 (most negative).

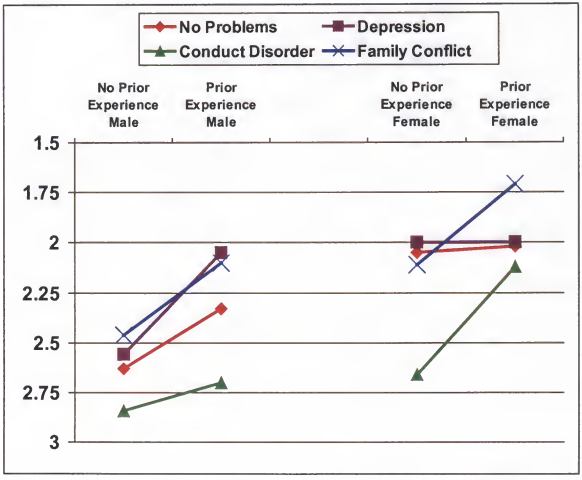

Figure 6. Interaction Effect for Emotional and Behavioral Problems x Prior Counseling Experience x Gender on the Adolescent Activity Preference List

Table 10. Estimated Marginal Means on the Adjective Checklist for Emotional and Behavioral Problems x Counseling Status x Perceived Similarity Interaction.

	No Counseling		Counseling	
Emotional & Behavioral Problem	Not Similar	Similar	Not Similar	Similar
No Problem	25.19	27.28	22.86	25.86
Depression	16.43	19.48	19.00	15.88
Conduct Disorder	14.67	14.25	16.18	16.60
Family Conflict	17.89	20.42	18.39	19.83

Note. Scores range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes

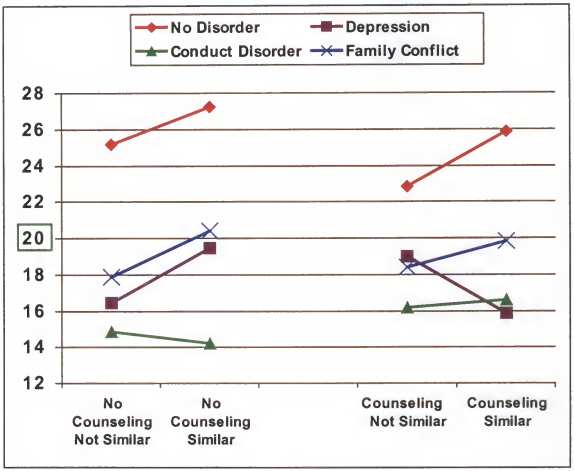

Figure 7. Interaction Effect for Perceived Similarity x Emotional and Behavioral Problems x Gender on the Adjective Checklist

Table 11. Estimated Marginal Means on the Adolescent Activity Preference List for Emotional and Behavioral Problems x Gender x Perceived Similarity Interaction

Emotional & Behavioral Problem	Male		Female	
	Not Similar	Similar	Not Similar	Similar
No Problem	2.68	2.41	2.16	1.98
Depression	2.45	2.24	2.05	1.86
Conduct Disorder	2.84	2.82	2.61	2.00
Family Conflict	2.49	2.05	2.02	2.10

Note. Scores range from 1 (most positive) to 4 (most negative).

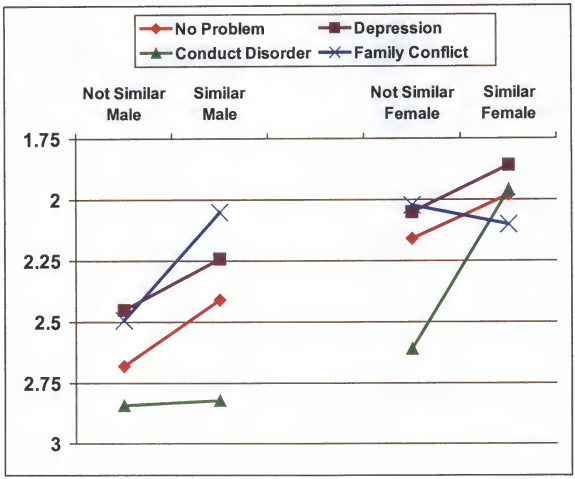

Figure 8. Interaction Effect for Perceived Similarity x Emotional and Behavioral Problems x Gender on the Adolescent Activity Preference List

Table 12. Estimated Marginal Means on the Adolescent Activity Preference List for Ethnicity x Emotional and Behavioral Problems Interaction

Emotional and Behavioral Problem	Caucasian	African-American
No Problem	2.34	2.05
Depression	2.12	2.31
Conduct Disorder	2.63	2.84
Family Conflict	2.16	2.23

Note. Scores range from 1 (most positive) to 4 (most negative).

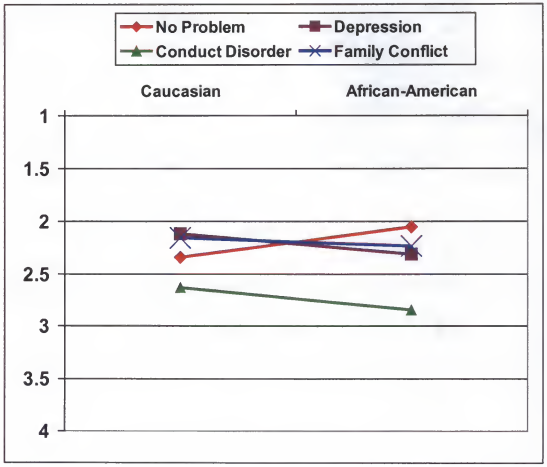

Figure 9. Interaction Effect for Ethnicity x Emotional and Behavioral Problem on the Adolescent Activity Preference List

Table 13. Estimated Marginal Means on the Adjective Checklist for Counseling Status x Gender x Grade Interaction

	No Counseling		Counseling	
Grade	Male	Female	Male	Female
9	17.31	20.09	18.57	20.52
10	18.59	20.92	19.22	19.13
11	17.52	20.43	18.73	20.45
12	21.25	19.31	16.18	20.66

Note. Scores range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes

Table 14. Estimated Marginal Means on the Adjective Checklist for Rurality x Counseling Status Interaction.

Counseling Status	In Town	In the Country
No Counseling	18.67	19.90
Counseling	20.29	19.14

Note. Scores range from 4 (most negative) to 36 (most positive). Scores over 20 indicate overall favorable attitudes, and scores below 20 indicate overall negative attitudes

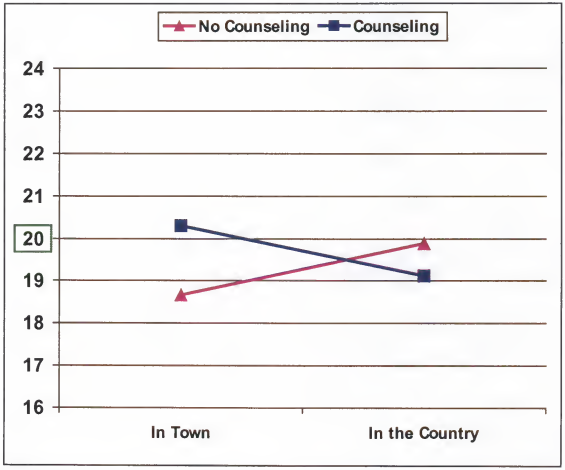

Figure 10. Interaction Effect for Rurality x Counseling Status on the Adjective Checklist

DISCUSSION

The primary goal of this study was to examine adolescents' attitudes toward common emotional and behavioral disorders and school-based counseling with a psychologist in a rural community. Five specific questions were addressed: (1) How do adolescents view peers with emotional or behavioral problems? (2) How do adolescents view peers who participate in counseling with a psychologist? (3) Do adolescents' views of peers change as a function of emotional and behavioral problems displayed and counseling status? (4) Do adolescents' attitudes toward peers with emotional and behavioral problems and those who attend counseling vary as a function of gender? (5) Do adolescents' attitudes toward peers with emotional and behavioral problems and those who attend counseling vary as a function of certain other respondent and demographic characteristics of the adolescent (e.g., perceived similarity to target adolescents, prior experience with counseling, help-seeking attitudes, grade, ethnicity, and rurality)? Attitudes were measured via an adjective checklist and a measure of behavioral intentions.

How Do Adolescents View Peers with Emotional and Behavioral Problems?

Adolescents had consistently less favorable attitudes toward peers described as exhibiting behaviors associated with depression, conduct disorder, and family conflict as compared to peers without such problems. On average, adolescents endorsed more negative and fewer positive descriptors for target peers described as having emotional

and behavioral problems; whereas adolescents endorsed more positive and fewer negative descriptors for target peers without such problems. However, on the measure of behavioral intentions, the negative effect of having an emotional or behavioral problem was only evident for peers with conduct disorder. Adolescents indicated less acceptance, as measured by willingness to engage in social activities, of peers who displayed conduct-disordered behaviors as compared to peers without apparent problems. In contrast, no differences in willingness to participate in activities were observed between peers without problems and those with depression or family conflict.

Since the descriptions of depression, family conflict, and conduct disorder included somewhat negative behaviors (e.g., not wanting to hang out with peers as much, arguing, fighting, getting upset more easily), these are likely to invoke negative perceptions, which could be easily indicated by some of the negative descriptors included on the Adjective Checklist. However, on the measure of behavioral intentions, adolescents did not evidence exclusionary behavior toward peers with depression and family conflict. Granted, individuals experiencing family conflict and depression may not be as "fun" for some activities, but based on the results of this study, they do not appear to be prone to exclusion from activities. Thus, despite somewhat negative attitudes toward peers with emotional and behavioral problems, these attitudes seem to have less of an effect on adolescents' willingness to interact with these peers. Peers with conduct disorder were the exception.

Adolescents consistently rated conduct-disordered peers significantly less favorably and were less willing to engage in social activities with them as compared to peers with family conflict, depression, or no problems. These findings are consistent with

previous research with young children suggesting that children who exhibit externalizing problems, and aggression in particular, are less well-liked (Coie & Pennington, 1976; Hoffman et al., 1977; Marsden et al., 1977) and frequently rejected (Coie et al., 1990). Indeed, the behaviors described within the conduct disorder vignettes (e.g., arguing, fighting, losing temper) are commonly associated with peer rejection in adolescence as well (Inderbitzen-Pisaruk & Foster, 1990).

Adolescents' increased cognitive ability also allows them to consider differences among emotional and behavioral problems relative to causal attributions, locus of control, and impact on others, which, in turn, could result in differential reactions to peers exhibiting symptoms of emotional and behavioral problems. For example, adolescents may attribute more personal responsibility (i.e., a person chooses to behave in such a manner or at least has more control over such behavior) for conduct-disordered behaviors as compared to behaviors associated with depression or family conflict. Likewise, problems such as depression and family conflict might be viewed as more external to the person, and as such, related to situational events and circumstances rather than personal choices. Such externally-based problems can inherently elicit more sympathy, understanding, and tolerance, and have less negative influence on adolescents' willingness to socialize with these peers. In addition, behaviors commonly exhibited by peers with conduct disorder (e.g., fighting, skipping school, stealing, etc.) often violate social norms and could result in negative consequences for both the individual and his or her peers. Specifically, adolescents, who are prosocial as a group and concerned about conformity to the peer group (regardless of gender), may be less willing to associate with peers who could get them into trouble. It is important to remember, however, that despite

their overall negative evaluation by the peer group, youth with conduct disorder are not necessarily friendless. In fact, rejection of aggressive and deviant peers by the prosocial or mainstream group frequently leads them to associate with similarly deviant peers and continued antisocial behavior. A group of antisocial youth may be rejected by the mainstream crowd, but the deviant peer group itself can provide acceptance and validation for conduct-disordered youth and their behaviors.

How Do Adolescents View Peers Who Attend Counseling with a Psychologist?

The impact of counseling on adolescents' attitudes was evident across the No Problems condition. Adolescents attributed less favorable attitudes toward peers without apparent problems if they participate in counseling. Thus, in the absence of any other negatively-valenced information (such as problem behaviors), the mere mention of counseling with a psychologist generated more negative opinions of these peers. In this respect, seeking mental health treatment may automatically generate negative stereotypes associated with having psychological problems, which has been suggested by previous research (Phillips, 1963; Piner & Kahle, 1984). Perhaps, peers attribute negative stereotypes, such as "only weak or dependent people need help" or "a person must have be really messed up to need counseling," when they do not know the reason for counseling.

At the same time, peers who attended counseling for no apparent reason still obtained significantly more favorable ratings than peers who exhibited behaviors associated with emotional and behavioral problems, regardless of whether or not they were receiving counseling. This finding suggests that the absolute magnitude of stigma related to the counseling versus no counseling conditions appears less than the degree of

stigma generated by the presence of emotional and behavioral problems, per se. In this respect, these results provide support for the primacy of stigma for emotional and behavioral problems relative to the stigma for counseling itself.

Alternatively, the relative lack of findings related to counseling may also reflect the location of psychological treatment and the treatment terminology used in the study. For example, more negative attitudes have also been found for individuals who have been characterized as seeing a psychiatrist or as having been hospitalized for mental illness (Nunally, 1961; Phillips, 1963). The term "counseling" may have less negative connotations than the term "therapy." Certainly, clinical experience with this population and the staff at the high school seem to suggest that the term "counseling" is more widely used and accepted and that the term "therapy" can elicit more negative connotations. Further, counseling with a psychologist, particularly one embedded within the school system, may trigger less negative stereotypes given the familiarity of location, particularly as compared to stereotypes that might be associated with being treated or medicated by a psychiatrist or with being hospitalized in a psychiatric ward.

Do Adolescents' Views of Peers Change as a Function of Emotional and Behavioral Problems Displayed and Counseling Status?

Contrary to expectations, perceptions of peers with emotional and behavioral problems did not improve greatly as a function of counseling status. Although adolescents had a slight tendency to rate target peers with conduct disorder more favorably if they attended counseling, the improved ratings did not significantly increase their status relative to peers with other emotional and behavioral problem conditions. Thus, peers with conduct disorder were still viewed most negatively independent of counseling status. Even though participation in counseling did not substantially improve

ratings of target peers with emotional and behavioral problems, there was no evidence to support greater negative attitudes as a function of attending counseling. This finding further supports that idea that stigma, in the form of negative evaluation, associated with emotional and behavioral problems is stronger than the stigma for attending counseling. In other words, adolescents may already have somewhat negative attitudes toward peers based on the behaviors they are exhibiting and knowledge of peers' participation in counseling seems to have little detrimental effect, and potentially some positive effect, on these negative attitudes. Although this finding may appear to be in contrast with previous research suggesting that individuals who seek help may be viewed more positively, or at least more competently (Dovidio et al., 1985), the measures used in this study assessed more global attitudes. Had this study used a multi-dimensional measure of attitudes and impressions, different results may have ensued.

Do Adolescents' Attitudes Toward Peers with Emotional and Behavioral Problems or Who Attend Counseling with a Psychologist Vary as a Function of Gender?

Gender produced significant effects, primarily in attitudes toward emotional and behavioral problems. It should be noted that the gender of the target peer matched the gender of the respondent; females always rated female target peers, and males always rated male target peers. Thus, effects related to females' perceptions of males and vice versa could not be examined. In general, female participants responded more positively to target peers across all vignette conditions relative to male participants, consistent with previous research (Lopez, 1991). Contrary to expectations, females did not view their same-sex peers with conduct disorder less favorably than males. At the same time, female peers in the conduct disorder condition were rated the least favorably compared to the other emotional and behavioral problem conditions. This finding is expected given the

lower prevalence rates and stereotypically non-normative nature of externalizing behaviors for females. For similar reasons, i.e., the lower prevalence rates and the stereotypically non-normative nature of internalizing problems for males, it was expected that males would rate their same sex peers with depression most negatively. It was also expected that males would have more positive ratings of peers with conduct disorder than females, given its higher prevalence rate and the more stereotypically normative nature of externalizing behaviors for males. Males rated their same-sex peers with depression lower relative to females' ratings of females with depression. However, males did not view their same-sex peers with conduct disorder any more favorably than females viewed females with conduct disorder. Males viewed same-sex peers with both conduct disorder and depression lower relative to peers with family conflict. It may be that the externalizing behaviors described (stealing and skipping school) in the vignettes are more severe than aggressive behaviors (such as fighting and asserting oneself) that might be more accepted among males. These findings again underscore the pervasive dislike of peers who have substantial externalizing problems.

While no gender differences emerged related for counseling per se, males and females did view counseling somewhat differently depending upon the emotional and behavioral problem condition. As compared to peers in the no counseling conditions, male participants gave more favorable ratings to same-sex target peers in family conflict and conduct disorder conditions who participated in counseling. It appears that males who experience depression and attend counseling could have "two strikes" against them when it comes to male peer perceptions. Already, males seem somewhat less accepting of peers with depression. Since they generally tend to have less favorable views of help-

seeking as well, it may be even more unacceptable if peers receive counseling for a problem that is not well-accepted. In contrast, males also may be more tolerant and understanding toward externalizing behaviors that could be somewhat more normative and stereotypical, and family conflict, which also tends to be more pervasive among adolescents. As such, males may be more understanding or cognizant of the potential value of counseling for these problems and deem these problems as more acceptable for counseling.

As expected, females participants gave higher ratings to same-sex target peers with depression who participated in counseling. In fact, females rated same-sex target peers with depressive symptoms who attended counseling the most favorably among the three emotional and behavioral problem conditions, and their ratings indicated a more favorable attitude overall. Female relationships tend to be more intimate and disclosing in nature than male relationships, and females tend to have more favorable attitudes toward help-seeking (Boldero & Fallon, 1995; Garland & Zigler, 1994; Schonert-Reichl et al., 1995). Consequently, they may have more positive attitudes towards discussing problems with someone else, particularly for peers with depression, which appears to be a more accepted problem among females.

Thus far, the results of this study provide support for stigma attached to behaviors commonly associated with depression, conduct disorder, and family conflict. Differences in adolescents' attitudes as a function of gender and counseling were less prominent. Despite these differences, however, attitudes toward peers with emotional and behavioral problems consistently remained below that of peers with no apparent problems, with the exception of depressed females who attended counseling. Although attending counseling

without an apparent reason resulted in slightly unfavorably attitudes, the attitudes of peers without emotional and behavioral problems remained significantly above that of peers with emotional and behavioral problems, regardless of counseling status. Overall, there was little evidence that counseling negatively impacted attitudes for peers who have emotional and behavioral problems, and in some instances, attending counseling actually improved attitudes slightly, particularly for females with depression.

Study results were more evident on the measure assessing evaluative judgments of peers as compared to the measure of behavioral intentions. Conduct disorder was the exception, which had significant effects on both dependent measures. The general lack of correspondence between the dependent measures likely reflects the small correlation between attitudes (i.e., cognitive and affective evaluation) and behaviors; attitudes do not always translate into behaviors (Ajzen & Fishbein, 1977). In this case, poor correspondence may be a good result. Specifically, the results suggest that negative evaluations may not significantly impact willingness to interact with youths who have emotional and behavioral problems, at least in relation to general social activities. It should be noted, however, that many of the activities listed in the measure of behavioral intentions were relatively impersonal and not reserved for close friendships. Findings from previous studies suggest that youth are less willing to befriend people with mental disorders or engage in more personal, intimate activities (Lopez, 1991; Reetz & Shemberg, 1985). In this respect, it remains unclear whether adolescents would initiate friendships with youth exhibiting symptoms of emotional and behavioral problem, or how adolescents might behave or react toward close friends who have emotional and behavioral problems.

Do Adolescent Demographic and Respondent Characteristics Affect Their Attitudes Toward Peers with Emotional and Behavioral Problems or Who Attend Counseling with a Psychologist?

Additional analyses examining the impact of respondent and demographic characteristics revealed another possible explanation for the lack of correspondence between the measures. Specifically, willingness to interact with peers differed as a function of the personal characteristics of the respondent in combination with counseling status or the behaviors associated with emotional and behavioral problems. In other words, characteristics related to having an emotional and behavioral problem or attending counseling may result in a negative evaluation for a peer, but it is characteristics of the adolescents themselves that seem to determine their actual willingness to interact socially with the peer. For the most part, the personal characteristics of the adolescents moderated effects related to emotional and behavioral problems rather than counseling status, contrary to original expectations.

For example, females who had prior counseling experience or who perceived the target peer as similar to themselves were equally willing to participate in activities with peers regardless of the presence or absence of emotional and behavioral problems. Remarkably, the lack of differentiation in acceptance ratings (i.e., behavioral intentions) among emotional and behavioral problems was largely accounted for by the large increase in females' willingness to engage in activities with peers exhibiting conduct-disordered behaviors if they had prior counseling experience themselves or perceived themselves as similar to the target peer. Surprisingly, males did not make the same differentiation or exception for their same-sex conduct-disordered peers. They continued to be least willing to socialize with same-sex peers with conduct disorder relative to other

conditions, regardless of previous counseling experience and perceived similarity. On the other hand, males' willingness to interact with peers with depression increased significantly if they had prior counseling experience themselves. It is interesting that the largest increases in willingness to participate in activities related to prior counseling experience or perceived similarity were for females considering same-sex peers with conduct disorder and males considering same-sex peers with depression—both disorders that are seen most negatively by each gender, respectively.

These findings make intuitive sense, in that perceived similarity likely engenders empathy and understanding, leading to greater tolerance and acceptance. Further support for this explanation derives from the fact that only a small number of adolescents rated themselves as similar to the target peer, particularly with respect to the target peers described as having emotional and behavioral problems. Given the ambiguity of the vignettes, it is likely that adolescents who may have experienced similar problems may have felt more affinity (similarity) with these peers based on the characteristics of the emotional and behavioral problems presented. Likewise, adolescents with prior counseling experience undoubtedly experienced some symptoms of emotional and behavioral problems themselves, and therefore have more empathy for peer with similar problems.

Along these lines, adolescents' increased ability to take perspective in combination with prior counseling experience or perceived similarity likely leads to better understanding of factors contributing to emotional and behavioral problems and generates more sympathy, or at least, less negative attitudes. Perhaps having prior counseling experience or perceiving oneself as similar to a peer with emotional and

behavioral problems could provide validity for the experience of conduct disorder for females and depression for males, problems not typically viewed as normative for each gender, respectively.

Ethnicity also produced small moderating effects as a function of emotional and behavioral problems. Specifically, African-American youth were significantly less willing to socialize with peers exhibiting conduct-disordered behaviors compared to peers with depression, family conflict, or no problems at all. This finding seems somewhat surprising. African-American youth are stereotypically portrayed by the media as endorsing or engaging in aggressive and delinquent behavior. Perhaps, because of this negative stereotype, the African American community pays greater attention to preventing youth from engaging in conduct-disordered behaviors and associating with deviant peers. Caucasian youth were actually more willing to participate in activities with peers who exhibited signs of depression relative to those with no problems. It is possible that behaviors associated with depression are less problematic in social interactions for Caucasian adolescents as compared to African-American adolescents; the exact reason for this is unclear. Interpretations of these data should be guarded until these results are replicated.

Individual characteristics also moderated several effects associated with counseling status, but not necessarily as expected, and the effects were related to general attitudes rather than behavioral intentions. For example, adolescents who perceived themselves as similar to the target peers generally rated them more favorably, with the exception of peers described as depressed and attending counseling. Contrary to expectations, depressed peers who participated in counseling were rated less favorably if

adolescents perceived the target peer as similar to them. It is possible that peers who perceived themselves as similar to the target peer in the depressed condition may have been experiencing feelings of depression themselves. The ambiguity of the vignette descriptions may have permitted projection of attitudes toward themselves. The lower rating of peers with depression who attended counseling may reflect feelings of hopelessness on the part of the respondent or feelings that depression is a problem that is either not appropriate for or amenable to counseling. Likewise, if adolescents perceive themselves as similar to the target peer with depression, they may be experiencing low self-esteem, less optimism, or depressive realism and project those feelings onto the peers in the vignette with similar problems. As a result, they attribute more negative descriptors to them. Alternatively, perhaps an adolescent experiencing depression and not receiving counseling may feel that depression is not a problem in need of counseling. Consequently, they may have more negative attitudes toward peers with depression who do attend counseling.

Slight grade effects also emerged, with males in the 12th grade rating their same-sex peers lower if they participated in counseling relative to those who did not participate in counseling. However, this unexpected and odd finding is contrary to previous literature and theoretical explanations related to age differences. Consequently, interpretation of this finding should be guarded until further research can either confirm or refute it.

Finally, and perhaps most notably, youths living in the country had less favorable views of adolescents in counseling as compared to youth living in town; it is noteworthy that findings related to rurality emerged, despite the somewhat imprecise designation of rurality (i.e., asking adolescents whether they lived "in town" or "in the country").

Additionally, no interaction between rural living conditions and type of emotional and behavioral problems emerged, suggesting that stigma for counseling was more evident among youth from predominantly rural, less populated areas. For this group of individuals, the stigma related to counseling may be more significant than stigma related to emotional and behavioral problems displayed by individuals. Although perceived stigma related to mental health services has been widely documented and associated with rural areas and linked with reluctance to seek mental health services when available (Berry & Davis, 1978; Stefl & Prosperi, 1985), this study empirically documented the existence of stigmatizing attitudes within a rural community. This finding is not necessarily surprising, however, given the potentially limited knowledge of rural residents about the nature of mental health services, lack of knowledge about common emotional and behavioral problems that counseling can effectively address, and traditional values that are incompatible with help-seeking (Hoyt et al., 1997; Wagenfeld et al., 1994).

Strengths and Future Directions

This study contributes significantly to the current literature on mental health stigma among adolescents. Specifically, this study assessed stigma mental health problems and treatment within the community setting rather than individually in the form of perceived stigma. Although perceived stigma can be an important barrier to seeking services, understanding the nature of attitudes prevalent in the community can facilitate addressing this issue . Do negative attitudes really exist? The results of this study suggest that they do, but with qualifications, depending on the type of emotional and behavioral problem displayed and personal characteristics, as described above.

This research also provides data on attitudes related to more common emotional and behavioral problems rather than chronic, severe mental illnesses. Stigma is unlikely to prevent individuals with severe mental illness for seeking or receiving treatment; whereas stigma most certainly can impact individuals' willingness to seek help for less severe, but nonetheless impairing, mental health problems. As such, stigma attached to common emotional and behavioral problems is highly relevant. Similarly, this study goes beyond the study of stigma attached to labels of "mental illness" by examining attitudes toward behaviors associated with common emotional and behavioral problems. There is a considerable body of literature suggesting that terms such as "mental illness" or "mental disorder" generate negative evaluations, but much less is known about specific mental health problems (with the exception of schizophrenia). This study also examines attitudes within an adolescent population, which has been largely ignored in this literature, and used developmentally appropriate, validated measures to empirically examine attitudes rather than relying on unstandardized qualitative or descriptive information.

This study also advances the study of stigma, by operationally defining stigma as an attitude and measuring both the evaluative and behavioral components of attitudes. Similar to previous attitudinal research, the results of this study suggest that these components of attitudes are distinctly different and yield different results. Consequently, researchers should continue to assess multiple aspects of attitudes in order to develop a more complete understanding of adolescent perceptions of and reactions to mental health problems and counseling. Further, it is likely that the components of attitudes may relate differently to actual behaviors.

A natural extension of this research would be to compare attitudes at the level of the community with both perceived stigma at the individual level as well as actual incidents of stigmatizing behaviors encountered by a clinic-referred, adolescent population. One could also assess the role of the peer group and friendships as a source of support for adolescents who have emotional and behavioral problems and seek help.

The vignette methodology used in this study also allows direct comparisons of the stigma related to mental health problems as compared to and in combination with counseling. The stigma associated with mental health problems and their treatment is easily confounded. This is one of the few studies (cf., Philips, 1963) that attempted to tease apart these attitudes, and it suggests that while negative attitudes are associated with seeking counseling, they tend to be less prominent than those associated with emotional and behavioral problems. Similar vignette paradigms could also be used to examine differences in mental health attitudes as a function of location (rural vs. urban) and service delivery (school vs. clinic).

Limitations

Although this study provides promising data about the prevalence of stigmatizing attitudes associated with mental health issues, several limitations restrict its generalizability. First and foremost, the study was hypothetical in nature, and as such, interactions with peers and attitudes in real-life situations may differ. Although designed to approximate typical behaviors, the stimuli presented were artificial and standardized in order to provide experimental control. Adolescents evaluated the peers in the vignettes based on behaviors exhibited in isolation. However, adolescent interactions with their peers are certainly not determined in isolation and are likely colored by a variety of

factors in addition to the presence of emotional and behavioral problems or attending counseling. Likewise, social desirability may have impacted responses, and more negativity surrounding emotional and behavioral problems and counseling may be present than indicated in this study. For example, adolescents could have answered the questionnaires in a socially desirable or somewhat naïve manner, suggesting that they would not discriminate against peers with characteristics of emotional and behavioral problems or who attend counseling. However, since the measure of social desirability did not correlate with the dependent measures, it is likely that social desirability was not a strong influence in responding.

Since adolescents only rated one target peer, it is possible that attitudes could differ within each individual. While adolescents as a group made distinctions between emotional and behavioral problems and counseling in this study, a single person may not make such distinctions. Finally, although the effects found in this study were statistically significant, their clinical significance is relatively unknown, particularly in terms of how these attitudes correlate with real-life reactions to peers with emotional and behavioral problems or who attend counseling.

It is also important to remember that the findings represent group averages. An individual or certain factions of a peer group may hold very different attitudes than the peer group as a whole. Unfortunately, there will likely be at least one person who stigmatizes, or acts negatively toward, another; this can be a highly salient event regardless of general peer group attitudes. A single individual who gossips, teases, or excludes a person from activities, or at least the fear of being stigmatized by such an individual, may be enough to prevent someone from seeking services. This is the

"perceived stigma" that is frequently cited as a barrier to help-seeking. Since the experience of stigma is highly individual, even if the prevalence of stigmatizing attitudes is not be great, the impact of a single stigmatizing episode can be great.

Lastly, it should be noted the definition of rurality was determined somewhat arbitrarily and imprecisely by asking adolescents to report whether they lived "in town" or "in the country". The youth who lived in town could also be considered "rural", given that the town in which they live has about 9,000 residents and larger communities are located some distance away. It would be interesting to examine whether effects differ among more precisely-defined populations in farming communities, small towns, suburban areas, and urban areas. The findings of this study should also be replicated in other, more diverse populations in order to document more accurately the prevalence of mental health stigma in adolescent populations.

Implications

Despite the above limitations, the results of this study do suggest that adolescent attitudes toward counseling may not be so unfavorable. At least, youth with emotional and behavioral problems appear to be evaluated somewhat negatively due to the behaviors they exhibit; attending counseling does not seem to worsen the stigma, with the exception of youth in rural areas. This finding has direct implications for the role of the peer group in facilitating help-seeking, for educational and marketing campaigns, and for school-based mental health services for adolescents.

First, adolescents frequently first seek help from informal sources, such as friends, and conformity to the peer group becomes increasingly important during this developmental period. While an individual may hold differing opinions than the peer

group, an individual's actions within a peer group are more likely to be consistent with or dictated by peer group. As such, a peer with emotional and behavioral problems might not necessarily be discouraged from going to counseling if the peer group has either generally positive or neutral attitudes, such as were found in this study. In addition, a peer group that does not hold stigmatizing attitudes could provide protection against potential teasing by individuals. Peer group influence can be highly salient in adolescence, providing a social reference for self-worth and guiding behavior (O'Brien & Bierman, 1988). If the prevailing attitude is supportive of counseling, it may discourage individuals from teasing or excluding a member of the peer group who attends counseling. Research has also consistently demonstrated that having at least one best friend can also provide a buffer against victimization, such as teasing and even, aggression (Boulton, Trueman, Chau, Whitehand, & Amatya, 1999; Hodges, Boivin, Vitaro, & Bukowski, 1999). Thus, while stigmatization can be a highly salient, individual event, the influence of a friend who has positive attitudes could be equally salient or protective.

The results of the study suggested that stigma, or negative attitudes, exists as a function of emotional and behavioral problems and attending counseling. As a result, additional education and programming needs to be directed toward adolescents to help them understand the nature and prevalence of emotional and behavioral problems, the nature of counseling, and the efficacy of counseling in treating emotional and behavioral problems. For example, APA's "Talk to Someone Who Can Help" and the "Warning Signs" campaigns are recent educational initiatives that could increase knowledge and promote open discussion, which could improve attitudes toward of peers with emotional and behavioral problems or who attend counseling. Peer support programs, like those

using peer counselors, have also been effective in facilitating health promotion (Turner, 1999). If mental health issues are incorporated into peer support programs, they could facilitate better understanding of emotional and behavioral problems, how to provide general support for friends or peers with these problems, provide information about existing mental health resources, and when/how to seek out such services. Further, the mere presence of a peer support program implicitly recognizes, at a school-wide level, that students frequently experience emotional and behavioral problems and could benefit from support. In this manner, peer support programs could also facilitate the discussion of frequently awkward or taboo topics.

Lastly but not least importantly, the findings of this study have particular implications for school-based mental health programs. Students have previously cited concerns about confidentiality, privacy, and embarrassment of others finding out about their problems or participation in counseling (Balassone et al., 1991; Dubow et al., 1990), suggesting that perceived stigma remains a highly salient concern and barrier to help-seeking. However, this study suggests that stigma within the peer group may not be as widespread as an adolescent or parent may think. Anecdotally, many parents and adolescents cite concerns about being stigmatized as a result of attending counseling. In fact, the results of this study suggest that it is the behaviors the adolescent is already exhibiting that result in rejection or exclusion from social activities. Counseling appears much less prominent as a stigmatizing factor. In fact, counseling is designed to address the very problematic behaviors that could lead to stigmatization in the first place. In this way, counseling could provide a buffering effect, so to speak, for the current problems an

adolescent may be experiencing. Providing parents and adolescents with this information may allay their concerns about counseling and provide increased motivation to seek help.

At the same time, concerns about confidentiality and privacy should still be heeded and addressed in setting up mental health services within the school, particularly in rural areas. Counseling should be integrated as part of already existing offices where students frequently come and go, such as guidance centers, administrative offices, or school health centers. However, it would be important the counseling office itself were not in direct view, but rather integrated into a suite of offices. Thus, adolescents receiving counseling are not singled out by going to an isolated room designated for counseling, but are also afforded some privacy and confidentiality within the common area. In this manner, school-based mental health services become more routine, part of the common facilities and services available to students, and easily accessible. Education should also be viewed as an integral part of school-based mental health programs as well. Research with adults suggest that they often frequently do not know how to access mental health services or the variety of problems that can be addressed with them, particularly within rural areas (American Psychological Association, 1996; Berry & Davis, 1978). The adolescent population is likely no different in their perceptions of mental health services and problems. Further, the results of this study suggest that while stigmatizing attitudes may not be as widespread as perceived, they do still exist. Individual education about the nature of emotional and behavioral problems and counseling and their potential impact on the adolescent's life, family, and peer relations should be provided at the outset of counseling. In addition, addressing concerns related to handling potential stigmatization (e.g., teasing or exclusion from activities) and confidentiality can be extremely important

factors in establishing rapport and credibility within a school-based clinic. In sum, the message needs to be spread that counseling can help ameliorate problems that might be already be negatively impacting social relationships, and that the counseling itself, may have either little negative, and perhaps some positive, impact on adolescents' perceptions of peers.

APPENDIX A
VIGNETTE DESCRIPTIONS[1]

1. *Male, Depressed, Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Lately, Michael has been missing school a lot and his grades have been going down. Michael has been feeling sad a lot and doesn't feel like hanging out with his friends as much as he used to. He's not eating or sleeping much. He doesn't seem to care much about anything and seems tired most of the time. Michael attends counseling every week with a psychologist who works at your school.

2. *Male, Depressed, No Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Lately, Michael has been missing school a lot and his grades have been going down. Michael has been feeling sad a lot and doesn't feel like hanging out with his friends as much as he used to. He's not eating or sleeping much. He doesn't seem to care much about anything and seems tired most of the time.

3. *Male, Conduct Disorder, Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Lately, Michael has been missing school a lot and his grades have been going down. Michael argues a lot with teachers and his parents. He gets angry easily and sometimes gets into physical fights with people or punches holes in walls. He's been caught stealing recently and skips school frequently. Michael attends counseling every week with a psychologist who works at your school.

4. *Male, Conduct Disorder, No Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Lately, Michael has been missing school a lot and his grades have been going down. Michael argues a lot with teachers and his parents. He gets angry easily and sometimes gets into physical fights with people or punches holes in walls. He's been caught stealing recently and skips school frequently.

5. *Male, Family Conflict, Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Lately, Michael has been missing school a lot and his grades have been going down. Michael and his parents fight all the time and he gets in trouble a lot at home. No one in Michael's family seems to be get along very well, and someone always seems to be yelling at someone else. Recently Michael seems to get upset more easily and has difficulty paying attention at school. Michael attends counseling every week with a psychologist who works at your school.

6. *Male, Family Conflict, No Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Lately, Michael has been missing school a lot and his grades have been going down. Michael and his parents fight all the time and he gets in trouble a lot at home. No one in Michael's family seems to get along very well, and someone always seems to be yelling at someone else. Recently Michael seems to get upset more easily and has difficulty paying attention at school.

7. *Male, No symptoms, Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes. Michael attends counseling every week with a psychologist who works at your school.

8. *Male, No symptoms, No Counseling*
   Michael just moved into your neighborhood a couple of weeks ago. He is about the same age as you and likes to do many of the same things you do. He has a brother, sister, and two pets at home. He is also in the same grade as you and attends many of your classes.

[1] Vignette wording was exactly the same for females, with the exception of changing the name Michael to Erica and changing the gender of pronouns as necessary.

APPENDIX B
ADJECTIVE CHECKLIST

If you had to describe Michael to your classmates, what kind of words would you use? Below is a list of words to help you. Circle the words you would use. You can use as many or as few as you want. Here is the list.

Smart	Dumb	Greedy
Weak	Slow	Bright
Dirty	Friendly	Honest
Helpful	Healthy	Selfish
Sad	Kind	Stupid
Lazy	Alert	Nice
Happy	Careless	Ugly
Lonely	Cheerful	Neat
Sloppy	Foolish	Careful
Ashamed	Clever	Unhappy
Good-looking	Glad	

Please list any other words you would use to describe this person:

_____ _____

_____ _____

_____ _____

APPENDIX C
ORIGINAL ACTIVITY PREFENCE LIST

Make believe that _____ is moving into your neighborhood and will be coming to your neighborhood. What types of activities would you like to do with _____? Below is a list of activities to help you decide. If you would like to do an activity with _____, circle YES. If you would not like to do an activity with _____, circle NO. If you are not sure, circle the question mark (?).

1. Watch TV together
2. Sit next to each other in class
3. Play games in class together.
4. Walk in the hall together..
5. Play on the same team in gym.
6. Eat at each others' homes.
7. Make or fix things together.
8. Work on a class project together.
9. Go sledding or ice skating together.
10. Share each others' pencils and things in school.
11. Learn spelling words together.
12. Invite to my house.
13. Go to public library or museum together
14. Listen to records at home together.
15. Eat lunch together in school.
16. Talk to each other in class.
17. Play games outside after school.
18. Color or draw together.
19. Sing or play an instrument together.
20. Play together during recess or snack time.
21. Go shopping at a store together.
22. Do math problems together.
23. Do errands for teacher together.
24. Go bicycle riding together.
25. Write a story or report together.
26. Play games inside my house together.
27. Go on a picnic or swimming together.
28. Lend my toy or game.
29. Do homework after school together.
30. Go to the movies together.

APPENDIX D
ADOLESCENT ACTIVITY PREFERENCE LIST

Pretend that Michael is moving into your neighborhood and will be coming to your class. What types of activities would you like to do with him? Below is a list of activities to help you decide. For each activity, circle one of the four choices which best describes how much you would like to do the activity with Michael.

1. Walk together to class	Like a lot	Like	Dislike	Dislike a lot
2. Sit next to each other in class	Like a lot	Like	Dislike	Dislike a lot
3. Talk to each other in class	Like a lot	Like	Dislike	Dislike a lot
4. Work on a class project together	Like a lot	Like	Dislike	Dislike a lot
5. Eat lunch together in school	Like a lot	Like	Dislike	Dislike a lot
6. Sit next to on the bus or ride to school together	Like a lot	Like	Dislike	Dislike a lot
7. Play sports together	Like a lot	Like	Dislike	Dislike a lot
8. Listen to music together	Like a lot	Like	Dislike	Dislike a lot
9. Make or fix things together	Like a lot	Like	Dislike	Dislike a lot
10. Invite to my house	Like a lot	Like	Dislike	Dislike a lot
11. Eat together after school	Like a lot	Like	Dislike	Dislike a lot
12. Do homework together	Like a lot	Like	Dislike	Dislike a lot
13. Hang out after school together	Like a lot	Like	Dislike	Dislike a lot
14. Work or play games on the computer together	Like a lot	Like	Dislike	Dislike a lot
15. Share CDs, movies, or electronic games (e.g., Playstation, N64, Gameboy, etc.)	Like a lot	Like	Dislike	Dislike a lot
16. Go shopping together	Like a lot	Like	Dislike	Dislike a lot
17. Go to the movie theater together.	Like a lot	Like	Dislike	Dislike a lot
18. Watch TV or movies together at home.	Like a lot	Like	Dislike	Dislike a lot
19. Talk on the phone or email each other	Like a lot	Like	Dislike	Dislike a lot

APPENDIX E
MANIPULATION CHECK QUESTIONS

Please answer the following questions about the story. (Depression)

1. Michael has 2 pets. ..... True False
2. Michael attends school all the time. ..... True False
3. Michael has been feeling sad. . ..... True False
4. Michael hangs out with his friends all the time. ..... True False
5. Michael attends counseling with a psychologist each week. True False

Please answer the following questions about the story. (Conduct Disorder)

1. Michael has 2 pets. ..... True False
2. Michael attends school all the time. ..... True False
3. Michael has been caught stealing. ..... True False
4. Michael gets along with everyone..... True False
5. Michael attends counseling with a psychologist each week. True False

Please answer the following questions about the story. (Family Conflict)

1. Michael has 2 pets. ..... True False
2. Michael attends school all the time. ..... True False
3. Michael has had trouble paying attention recently. ..... True False
4. Michael's family hardly ever fights. ..... True False
5. Michael attends counseling with a psychologist each week. True False

APPENDIX F
HELP SEEKING SCALE

Please give us the following information about yourself.

Grade:_____ **Age:**_____ **Gender:** Male Female

Race: White Black Hispanic Other_____

Circle the phrase that best describes where you live: in town in the country

---

Start with these warm-up questions; please circle your answers:

I would rather win than lose in a game .... Yes No

I get angry sometimes .... Yes No

I always tell the truth. .... Yes No

I gossip a little at times..... .... Yes No

I always do all my homework before I watch TV..... .... Yes No

Choose the answers that best describes how you feel.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Adults are good at helping kids with personal or emotional problems.	1	2	3	4
2. The best way to deal with personal problems is to keep them to yourself.	1	2	3	4
3. Just talking with someone about things that bother you can be helpful.	1	2	3	4
4. School is not the right place to talk about personal or family problems.	1	2	3	4
5. When you have a problem, you have to help yourself.	1	2	3	4

Choose the answers that best describes how you feel.

	Strongly Agree	Agree	Disagree	Strongly Disagree
6. I would tell a friend to talk to a counselor or therapist if he/she were very upset about a family problem.	1	2	3	4
7. If you are really sad, it is usually a good idea to keep these feelings to yourself.	1	2	3	4
8. Most adults can't be trusted to keep	1	2	3	4
9. I would be willing to talk to someone who helps people with their problems, if I felt sad.	1	2	3	4
10. I don't think counselor or therapists know much about how students feel.	1	2	3	4
11. If I were worried that a member of my family might hurt himself/herself, I would talk to another adult about it.	1	2	3	4
12. Talking with an adult about your problems might help you solve them.	1	2	3	4
13. I can only talk to someone my own age about my problems.	1	2	3	4
14. I would talk to an adult at school about problems in my family.	1	2	3	4
15. Therapists and/or counselors can help when you're upset about a personal problem.	1	2	3	4
16. There should be an adult at school who talks to kids about personal problems and family problems.	1	2	3	4

17. Who do you talk to when you're sad or upset? (Circle as many answers as you want.)

Parent	Friend	Brother or Sister	Teacher
Counselor	Other adult	No one	

18. Have you ever talked to a therapist or counselor about a personal or emotional problem?	Yes	No
19. Has a family member or relative ever talked to a therapist or counselor about a personal or emotional problem?	Yes	No
20. Has one of your friends ever talked to a therapist or counselor about a personal or emotional problem?	Yes	No
21. Have you ever talked to a therapist or a counselor, because you were worried about a friend who was having some problems?	Yes	No

Try to imagine that you had each of the following experiences. Would you talk to an adult about these things?

	Definitely YES	Probably	Probably Not	Definitely NO
22. You felt extremely sad and couldn't concentrate on school.	1	2	3	4
23. You had a fight with a friend.	1	2	3	4
24. You were scared of things other people aren't usually scared of	1	2	3	4
25. You were very upset because your best friend moved away.	1	2	3	4
26. You felt very lonely and wanted more friends.	1	2	3	4
27. You were worried about a friend who was using drugs.	1	2	3	4
28. You were very sad because someone in your family was sick.	1	2	3	4

APPENDIX G
LETTER TO PARENTS

Dear Parents:

On _____ during one of your teenager's classes, we will be asking your teenager to write down answers to some questions about their opinions of classmates who have emotional or behavioral problems and seek help from a counselor for these problems. In short, your teenager will read a short story about an imaginary new student and then answer questions about their opinions of this student and about seeking help. The decision to participate is entirely up to your teenager. Students who do not participate will be allowed to work quietly at their desk. No identifying information, such as names or dates of birth, will be collected. No person's answers will ever be shown alone, and no one will be able find out a specific person's answers. The information we learn will help the school make better decisions about how to help teenagers who are having problems. The question session should only last about 20-30 minutes. We look forward to your teenager's participation and appreciate your willingness to help us find out more about the best way to help teens who are having problems. If you have any questions or concerns, please contact Caroline Danda at (352) 265-0680 ext. 46864. If you do not want your teenager to participate, please notify the office (Attention:_____), in writing or call Caroline Danda at (352) 265-0680 ext. 46864 by _____.

Sincerely,

Gloria Spivey
Student Outreach Services
Columbia County School System

Terry Huddleston
Principal
Columbia High School

Caroline Elder Danda, B.A.
Doctoral Candidate
University of Florida

Garret D. Evans, Psy.D.
Assistant Professor
University of Florida

APPENDIX H
COVER LETTER TO ADOLESCENT

Hello:

We would like for you to read the following story. After you read the story, we will ask you to write down answers to some questions. There are no right or wrong answers. Please be honest. Your answers will not be shown to anyone, and no one can find out how you answered the questions. Do NOT put your name on any of these forms. The information we learn from everyone's answers will help the school make better decisions about how to help teenagers who are having problems. It shouldn't take too long.

You do not have to answer these questions, and you can stop answering them at anytime. If you choose not to answer the questions, you may work quietly at your desk. We look forward to your participation. Your answers are important to us and much appreciated. Thank you.

APPENDIX I
DEBRIEFING STATEMENT

Thanks to all of you who answered our questions today. We very much appreciate your help. Often teenagers experience emotional or behavioral problems, such as depression, conduct problems, and family conflict, but many do not get help. More psychologists (counselors) are now working in schools to help teenagers with such problems. (You can ask your guidance counselor if you want more information about counselors working with your school). So, we wanted to understand teenagers' views of classmates who have these problems and who get help from a psychologist for these problems. The answers you gave us today will help us learn more about the best way to help students who have emotional and behavioral problems get help. Thanks again for all of your help. If you have any questions or concerns, you can talk to your guidance counselor or call Caroline Danda at (352) 265-0680 x 46864.

LIST OF REFERENCES

Achenbach, T., Howell, C., Quay, H., & Conners, K. (1991). National survey of problems and competencies among four- to sixteen-year-olds: Parents' reports for normative and clinical samples. Monographs of the Society for Research in Child Development, 56(3, Serial No. 225), v-120.

Adelman, H. S., & Taylor, L. (1993). School-based mental health: Toward a comprehensive approach. Journal of Mental Health Administration, 20(1), 32-45.

Ajzen, I., & Fishbein, M. (1977). Attitude-behavior relations: A theoretical analysis and review of empirical research. Psychological Bulletin, 84, 888-918.

Alexander, C. S., & Becker, H. J. (1978). The use of vignettes in survey research. Public Opinion Quarterly, 42(1), p 93-104.

American Psychological Association (1996). Survey of public perceptions of the value of psychological services: Executive Summary. Washington, DC: American Psychological Association.

Anglin, T. M., Naylor, K. E., & Kaplan, D. W. (1996). Comprehensive school-based health care: High school students' use of medical, mental health, and substance abuse services. Pediatrics, 97(3), 318-330.

Bak, J., & Siperstein, G. (1986). Protective effects of the label "mentally retarded" on children's attitudes toward mentally retarded peers. American Journal of Mental Deficiency, 91(1), 95-97.

Balassone, M. L., Bell, M., & Peterfreund, N. (1991). A comparison of users and nonusers of a school-based health and mental health clinic. Journal of Adolescent Health, 12(3), 240-246.

Berry, B., & Davis, A. E. (1978). Community mental health ideology: A problematic model for rural areas. American Journal of Orthopsychiatry, 48(4), 673-679.

Boldero, J., & Fallon, B. (1995). Adolescent help-seeking: What do they get help for and from whom? Journal of Adolescence, 18(2), 193-209.

Boulton, M. J., Trueman, M., Chau, C., Whitehand, C., & Amatya, K. (1999). Concurrent and longitudinal links between friendship and peer victimization: Implications for befriending interventions. Journal of Adolescence, 22, 461-466.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. Health Affairs, 14(3), 147-159.

Burstin, K., Doughtie, E. B., & Raphaeli, A. (1980). Contrastive vignette technique: An indirect methodology to address reaction social attitude measurement. Journal of Applied Social Psychology, 10(2), 147-165.

Chassin, L., & Coughlin, P. (1983). Age differences in children's attributions for deviant behaviors. Psychiatry, 46(2), 181-185.

Chimonides, K. M., & Frank, D. I. (1998). Rural and urban adolescents' perceptions of mental health. Adolescence, 33(132), 823-830.

Cohen, P., & Hesselbart, C. (1993). Demographic factors in the use of children's mental health services. American Journal of Public Health, 83(1), 49-52.

Coie, J., & Pennington, B. (1976). Children's perceptions of vulnerability of deviance and disorder. Child Development, 47, 407-413.

Coie, J. D., Dodge, K. A., & Kupersmidt, J. B. (1990). Peer group behavior and social status. In S. R. Asher & J. D. Coie (Eds.), Peer rejection in childhood (pp. 17-59). New York: Cambridge University Press.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. American Psychologist, 54(9), 765-776.

Crisp, A. H., Gelder, M. G., Rix, S. R., Meltzer, H. I., & Olwen, O. J. (2000). Stigmatization of people with mental illnesses. British Journal of Psychiatry, 177, 4-7.

Danda, C. E., Evans, G. D., Rey, J., & Nitzberg, R. (2000). Utilization patterns and patient characteristics in a mental health and violence prevention service delivery model. Paper presented at the Kansas Conference on Clinical Child Psychology, Lawrence, KS.

Day, L., & Reznikoff, M. (1980). Social class, the treatment process, and parents' and children's expectations about child psychotherapy. Journal of Clinical Child Psychology, 9(3), 195-198.

Dollinger, S. J., & Thelen, M. H. (1978). Children's perceptions of psychology. Professional Psychology, 9(1), 117-126.

Dollinger, S. J., Thelen, M. H., & Walsh, M. L. (1980). Children's conceptions of psychological problems. Journal of Clinical Child Psychology, 9(3), 191-194.

Dovidio, J. F., Fishbane, R., & Sibicky, M. (1985). Perceptions of people with psychological problems: Effects of seeking counseling. Psychological Reports, 57(3, Pt 2), 1263-1270.

Dubow, E. F., Lovko, K. R., & Kausch, D. F. (1990). Demographic differences in adolescents' health concerns and perceptions of helping agents. Journal of Clinical Child Psychology, 19(1), 44-54.

Evans, G. D., & Rey, J. (2001). In the echoes of gunfire: Practicing psychologists' responses to school violence. Professional Psychology: Research and Practice, 32(2), 157-164.

Evans, S. W. (1999). Mental health services in schools: Utilization, effectiveness, and consent. Clinical Psychology Review, 19(2), 165-178.

Farmer, E. M., Stangl, D. K., Burns, B. J., Costello, E. J., & Angold, A. (1999). Use, persistence, and intensity: patterns of care for children's mental health across one year. Community Mental Health Journal, 35(1), 31-46.

Fischer, E. H., & Turner, J. I. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 35(1, Pt. 1), 79-90.

Flaherty, L. T., Weist, M. D., & Warner, B. S. (1996). School-based mental health services in the United States: History, current models and needs. Community Mental Health Journal, 32(4), 341-352.

Fothergill, K., & Ballard, E. (1998). The school-linked health center: A promising model of community-based care for adolescents. Journal of Adolescent Health, 23, 29-38.

Garland, A. F., & Zigler, E. F. (1994). Psychological correlates of help-seeking attitudes among children and adolescents. American Journal of Orthopsychiatry, 64(4), 586-593.

Halgin, R. P., & Weaver, D. D. (1986). Salient beliefs about obtaining psychotherapy. Psychotherapy in Private Practice, 4(1), 23-31.

Hargrove, D., & Breazeale, R. (1993). Psychologists and rural services: Addressing a new agenda. Professional Psychology: Research and Practice, 24(3), 319-324.

Hayward, P., & Bright, J. A. (1997). Stigma and mental illness: A review and critique. Journal of Mental Health UK, 6(4), 345-354.

Hodges, E. V. E., Boivin, M., Vitaro, F., & Bukowski, W. M. (1999). The power of friendship: Protection against an escalating cycle of peer victimization. Developmental Psychology, 35(1), 94-101.

Hoffman, E., Marsden, G., & Kalter, N. (1977). Children's understanding of their emotionally disturbed peers: A replication. Journal of Clinical Psychology, 33(4), 949-953.

Hoyt, D., Conger, R., Valde, J., & Weihs, K. (1997). Psychological distress and help seeking in rural America. American Journal of Community Psychology, 25(4), 449-470.

Inderbitzen-Pisaruk, H., & Foster, S. L. (1990). Adolescent friendships and peer acceptance: Implications for social skills training. Clinical Psychology Review, 10(4), 425-439.

Kaser Boyd, N., Adelman, H. S., & Taylor, L. (1985). Minors' ability to identify risks and benefits of therapy. Professional Psychology: Research and Practice, 16(3), 411-417.

Kashani, J., Beck, N., Hoeper, E., Fallahi, C., Corcoran, C., McAllister, J., Rosenberg, T., & Reid, J. (1987). Psychiatric disorders in a community sample of adolescents. American Journal of Psychiatry, 144(5), 584-589.

Kelleher, K. J., Taylor, J. L., & Ricker, V. I. (1992). Mental health services for rural children and adolescents. Clinical Psychology Review, 12, 841-852.

Kenkel, M. (1986). Stress-coping-support in rural communities: A model for primary prevention. American Journal of Community Psychology, 14(5), 457-477.

Lanza, M. L., & Carifio, J. (1992). Use of a panel of experts to establish validity for patient assault vignettes. Evaluation Review, 17(1), 82-92.

Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horwitz, S. M., Hoven, C. W., Narrow, W. E., Vaden Kiernan, M., & Regier, D. A. (1996). Mental health service use in the community and schools: Results from the four-community MECA Study. Journal of the American Academy of Child and Adolescent Psychiatry, 35(7), 889-897.

Lopez, L. R. (1991). Adolescents' attitudes towards mental illness and perceived sources of their attitudes: An examination of pilot data. Archives of Psychiatric Nursing, V(5), 271280.

Marsden, G., Kalter, N., Plunkett, J., & Barr-Grossman, T. (1977). Children's social judgments concerning emotionally disturbed peers. Journal of Consulting and Clinical Psychology, 45(5), 948.

McMiller, W. P., & Weisz, J. R. (1996). Help-seeking preceding mental health clinic intake among African-American, Latino, and Caucasian youths. Journal of the American Academy of Child and Adolescent Psychiatry, 35(8), 1086-1094.

Morgan, S. B., & Wisely, D. W. (1996). Children's attitudes and behavioral intentions toward a peer presented as physically handicapped: A more positive view. Journal of Developmental and Physical Disabilities, 8(1), 29-42.

Norman, R. M., & Malla, A. K. (1983). Adolescents' attitudes towards mental illness: Relationship between components and sex differences. Social Psychiatry, 18(1), 45-50.

Novak, D. (1974). Children's reactions to emotional disturbance in imaginary peers. Journal of Consulting and Clinical Psychology, 42, 462.

O'Brien, S. F., & Bierman, K. L. (1988). Conceptions and perceived influence of peer groups: Interviews with preadolescents and adolescents. Child Development, 59(5), 1360-1365.

Offer, D., Howard, K. I., Schonert, K. A., & Ostrov, E. (1991). To whom do adolescents turn for help? Differences between disturbed and nondisturbed adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 30(4), 623-630.

Offer, D., & Schonert Reichl, K. A. (1992). Debunking the myths of adolescence: Findings from recent research. Journal of the American Academy of Child and Adolescent Psychiatry, 31(6), 1003-1014.

Office of Technology Assessment, U. S. Congress (1991). Adolescent health. Volume I. Summary and policy options. Washington, DC: U.S. Government Printing Office.

Offord, D., Boyle, M., Statmari, P., Rae-Grant, N., Links, P., Cadman, D., Boyles, J., Crawford, J., Blum, H., Byrne, C., Thomas, H., & Woodward, C. (1987). Ontario child health study: Six-month prevalence of disorder and rates of service utilization. Archives of General Psychiatry, 44, 832-836.

Ostrov, E., Offer, D., & Howard, K. I. (1989). Gender differences in adolescent symptomatology: A normative study. Journal of the American Academy of Child and Adolescent Psychiatry, 28(3), 394-398.

Padgett, D. K., Patrick, C., Burns, B. J., & Schlesinger, H. J. (1994). Ethnicity and the use of outpatient mental health services in a national insured population. American Journal of Public Health, 84(2), 222-226.

Parish, T., Ohlsen, R., & Parish, J. (1978). A look at mainstreaming in light of children's attitudes toward the handicapped. Perceptual and Motor Skills, 46, 1019-1021.

Parish, T. S., & Kappes, B. M. (1979). Affective implications of seeking psychological counseling. Journal of Counseling Psychology, 26(2), 164-165.

Phillips, D. L. (1963). Rejection: A possible consequence of seeking help for mental disorders. American Sociological Review, 28(6), 963-972.

Phillips, D. L. (1964). Rejection of the mentally ill: The influence of behavior and sex. American Sociological Review, 29(5), 679-687.

Piner, K. E., & Kahle, L. R. (1984). Adapting to the stigmatizing label of mental illness: Foregone but not forgotten. Journal of Personality and Social Psychology, 47(4), 805-811.

Pugh, R. L., Ackerman, B. J., McColgan, E. B., & de Mesquita, P. B. (1994). Attitudes of adolescents toward adolescent psychiatric treatment. Journal of Child & Family Studies, 3(4), 351-363.

Reetz, M., & Shemberg, K. M. (1985). Fifth and sixth graders' attitudes toward mental health issues. Journal of Community Psychology, 13(4), 393-401.

Rickwood, D., & Braithwaite, V. (1994). Social-psychological factors affectign help-seeking for emotional problems. Social Science Medicine, 39(4), 563-572.

Roberts, M. C., Johnson, A. Q., & Beidleman, W. B. (1984). The role of socioeconomic status on children's perceptions of medical and psychological disorders. Journal of Clinical Child Psychology, 13(3), 243-249.

Santelli, J., Morreale, M., Wigton, A., & Grason, H. (1996). School health centers and primary care for adolescents: A review of the literature. Journal of Adolescent Health, 18, 357-366.

Saunders, S. M., Resnick, M. D., Hoberman, H. M., & Blum, R. W. (1994). Formal help-seeking behavior of adolescents identifying themselves as having mental health problems. Journal of the American Academy of Child and Adolescent Psychiatry, 33(5), 718-728.

Schonert-Reichl, K. A., Offer, D., & Howard, K. I. (1995). Seeking help from informal and formal resources during adolescence: Sociodemographic and psychological correlates. In R. C. Marohn (Ed.), Adolescent psychiatry: Developmental and clinical

studies, Vol. 20. Annals of the American Society for Adolescent Psychiatry (pp. 165-178). Hillsdale, NJ: Analytic Press, Inc.

Schwarzer, R., & Weiner, B. (1991). Stigma controllability and coping as predictors of emotions and social support. Journal of Social and Personal Relationships, 8, 133-140.

Sibicky, M., & Dovidio, J. F. (1986). Stigma of psychological therapy: Stereotypes, interpersonal reactions, and the self-fulfilling prophecy. Journal of Counseling Psychology, 33(2), 148-154.

Sigelman, C. K., & Mansfield, K. A. (1992). Knowledge of and receptivity to psychological treatment in childhood and adolescence. Journal of Clinical Child Psychology, 21(1), 2-9.

Siperstein, G. (1980). Instruments for measuring children's attitudes towards the handicapped. Unpublished manuscript, University of Massachusetts at Boston.

Stefl, M. E., & Prosperi, D. C. (1985). Barriers to mental health service utilization. Community Mental Health Journal, 21, 167-178.

Surgeon General (2000). Mental Health: A Report of the Surgeon General. Washington, DC: Author.

Taylor, L., Adelman, H. S., & Kaser Boyd, N. (1985). Exploring minors' reluctance and dissatisfaction with psychotherapy. Professional Psychology: Research and Practice, 16(3), 418-425.

Turner, G. (1999). Peer support and young people's health. Journal of Adolescence, 22, 567-572.

Wagenfeld, M., Murray, J., Mohatt, D., & DeBruyn, J. (1994). Mental health and rural America: 1980-1993. An overview and annotated bibliography. Washington, DC: Public Health Service.

Weist, M., Paskewitz, D., Warner, B., & Flaherty, L. (1996). Treatment outcome of school-based metnal health services for urban teenagers. Community Mental Health Journal, 32(2), 149-157.

Whitaker, A., Johnson, J., Shaffer, D., Rapoport, J., Kalikow, K., Walsh, B., Davies, M., Braiman, S., & Dolinsky, A. (1990). Uncommon troubles in young people: Prevalence estimates of selected psychiatric disorders in a nonreferred population. Archives of General Psychiatry, 47(487-496).

Wisely, D., & Morgan, S. (1981). Children's ratings of peers presented as mentally retarded and physically handicapped. American Journal of Mental Deficiency, 86(3), 281-286.

Zahner, G., Pawelkiewicz, W., DeFrancesco, J., & Adnopoz, J. (1992). Children's mental health service needs and utilization patterns in an urban community: An epidemiological assessment. Journal of the American Academy of Child & Adolescent Psychiatry, 31(5), 951-960.

BIOGRAPHICAL SKETCH

Caroline Elder Danda is currently a doctoral student in the Department of Clinical and Health Psychology at the University of Florida. In 1993, she graduated with bachelor's degree in Psychology and French from the University of Missouri-Columbia, where she worked on an honors' thesis assessing the peer relations of juvenile offenders with Dr. Charles Borduin and Dr. Ally Burr-Harris. Prior to beginning graduate school at the University of Florida in 1996, she worked with Dr. Michael Harris in St. Louis as the project coordinator for Dr. Tim Wysocki's grant examining Behavior Family Systems Therapy for adolescents with diabetes. During the 2001-2002 academic year, she will complete an internship in pediatric and child psychology at Children's Mercy Hospital in Kansas City, Missouri. Her primary interests are child and pediatric psychology, the practice of psychology in primary care, peer relations, attitudes towards psychological treatment, and advocacy for the profession of psychology.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Garret D. Evans, Chair
Associate Professor of Clinical and Health Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Suzanne Bennett Johnson, Co-chair
Professor of Clinical and Health Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Samuel F. Sears
Associate Professor of Clinical and Health Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Sheila M. Eyberg
Professor of Clinical and Health Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Steven G. Jacob
Assistant Professor of Family, Youth, and Community Sciences

This dissertation was submitted to the Graduate Faculty in the College of Health Related Professions and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August 2002

Robert C. Frank
Dean, College of Health Professions

Dean, Graduate School

This dissertation was submitted to the Graduate Faculty in the College of Health Related Professions and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August 2002

Robert C. Frank
Dean, College of Health Professions

Dean, Graduate School